90-1711

Supreme Court, U.S.
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In the Supreme Court of the United States

Term, 1990

GLADYS M. GRIDLEY,

Petitioner

vs.

CLEVELAND PNEUMATIC COMPANY, a subsidiary of Pneumo Corporation, a subsidiary of IC Industries; MARJORIE ANN SMITH, individually and as Manager of Employee Benefits and Services; PATRICIA BORAH, individually and as Employee Benefits Administrator; JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY.

CLEVELAND PNEUMATIC COMPANY, a subsidiary of Pneumo Corporation,

Respondent

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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STATEMENT OF QUESTIONS PRESENTED FOR REVIEW

1. Whether an employee benefit brochure distributed by a plan administrator to employees constitutes a summary plan description under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001, *et seq.*, when the brochure summarizes benefits and the plan administrator testifies that the brochure was considered by it to be the summary plan description for a new benefits package?

2. Whether ERISA affords to participants and beneficiaries a meaningful remedy for the failure of the plan administrator to comply with the statutory mandate to supply a summary plan description which contains conditions of eligibility, disqualification and denial or loss of benefits?

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IN THE SUPREME COURT OF THE UNITED STATES

GLADYS M. GRIDLEY,

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vs.

CLEVELAND PNEUMATIC COMPANY, a subsidiary of Pneumo Corporation, a subsidiary of IC Industries; MARJORIE ANN SMITH, individually and as manager of Employee Benefits and Services; PATRICIA BORAH, individually and as Employee Benefits Administrator; JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY

CLEVELAND PNEUMATIC COMPANY, a subsidiary of Pneumo Corporation,

Respondent

PETITION FOR WRIT OF CERTIORARI

To the Honorable, the Chief Justice and the Associate Justices of the Supreme Court of the United States

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William A. Hebe, Counsel of Record, respectfully presents this Petition to the Supreme Court of the United States.

REFERENCE TO CITATIONS TO THE OPINIONS AND JUDGMENTS DELIVERED IN THE COURTS BELOW

The District Court for the Middle District of Pennsylvania issued an Opinion and Order, 73 pages in length, which have not been officially reported, and the Third Circuit Court of Appeals reversed with Opinion, 924 F.2d 1310 (3d Cir. 1991). The Slip Opinion and Judgment Order are reproduced in the Appendix to this Petition for Writ of Certiorari.

JURISDICTION

The Third Circuit Court of Appeals entered its Order reversing the decision of the District Court for the Middle District of Pennsylvania on February 4, 1991. This Petition for Writ of Certiorari was filed within ninety (90) days of that date. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

This is an action seeking benefits under an ERISA controlled fringe benefit plan so that jurisdiction is vested in the Federal District Court pursuant to 29 U.S.C. §1451(c) in the first instance.

STATUTES INVOLVED

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§1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power. The Congress finds ... that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of [employee benefit] plans....

29 U.S.C. §1001(a)

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries. It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. §1001(b)

§1021. Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneficiaries. The administrator of each employee benefit plan shall cause to be furnished in accordance with section 104(b) [29 U.S.C.S. §1024(b)] to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan—

(1) a summary plan description described in section 102(a)(1) [29 U.S.C.S. §1022(a)(1)]....

29 U.S.C. §1021(a)(1)

§1022. Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 104(b) [29 U.S.C.S. §1024(b)]. The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 104(b)(1) [29 U.S.C.S. §1024(b)(1)].

29 U.S.C. §1022(a)(1)

§1022(b).

The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the

records of the plan are kept on a calendar, policy or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part....

29 U.S.C. §1022(b)

§1024. Filing and furnishing of information

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan. Publication of the summary plan description and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary plan description, and all modifications and changes referred to in section 102(a) (1) [29 U.S.C.S. §1022(a)(1)]—

(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or

(B) if later, within 120 days after the plan becomes subject to this part.

29 U.S.C. §1024(b)(1)(A)(B)

STATEMENT OF THE CASE

This ERISA action was brought by the Plaintiff, Gladys M. Gridley, widow of Joseph Gridley, against Cleveland Pneumatic Company and individual employees of Cleveland Pneumatic, Smith and Borah, and John Hancock Mutual Life Insurance Company, seeking life insurance benefits under a new benefit plan which went into effect January 1, 1986. The case was tried before District Judge Malcolm Muir, who rendered a verdict in favor of the Plaintiff against Cleveland Pneumatic Company in $134,000 and in favor of the remaining Defendants, John Hancock Mutual Life Insurance Company, Marjorie Ann Smith and Patricia Borah, on February 21, 1990. Judge Muir's Opinion contained 244 Findings of Fact, 20 Conclusions of Law, and was 72 pages in length.

On appeal, the Third Circuit Court of Appeals reversed. That Court found that an employee benefit brochure distributed by the plan administrator to Plaintiff in November of 1985 was not a summary plan description, despite the plan administrator's and Judge Muir's finding that it was. The Court further found that even if the brochure were a summary plan description, ERISA affords no remedy for violations of mandated reporting or disclosure requirements. This Petition for Writ of Certiorari is filed in response to the Opinion and Order of the Third Circuit Court of Appeals.

The following facts are taken from District Court Judge Muir's Findings of Fact. Petitioner's decedent was employed by Cleveland Pneumatic Company ("Cleveland"), as a manufacturing engineer, on June 5, 1985 (Finding of Fact ("F.F.") 36, App. 35a). At the time of his employment, decedent received a number of brochures describing fringe benefits. One of the documents he received was an insurance "certificate" prepared by John Hancock for distribution to Cleveland salaried employees, describing the group life insurance benefit (F.F. 25-28, App. 32a). The Cleveland group life insurance benefit was underwritten by John Hancock, and the insurance policy or contract entered into between Cleveland and John Hancock

contained a requirement that to be entitled to an increase in benefits, an employee had to be "actively at work" on the date the increase became effective or the increase would not become effective until the employee returned to "active work" (F.F. 29, App. 33a).

At the time of his employment, decedent was also provided with a glossy, fold-out brochure entitled "Employee Benefits Summary" (Plaintiff's Exhibit 15). The Employee Benefits Summary contained information with regard to a variety of fringe benefits including group life insurance. In terms of eligibility, it stated, "You are automatically eligible to participate in our life insurance plans on your first day of employment with the Company." In terms of amount, it provided for basic life insurance of one and one-half times the employee's annual salary rounded to the next higher $1,000 and voluntary life insurance to be paid for by the employee at group rates equal to one-half of the employee's annual salary rounded to the next higher multiple of $1,000 (F.F. 45, App. 36a-37a).

At the time of his employment, decedent selected voluntary life insurance in the amount of one-half his annual salary rounded to the next higher $1,000 by completing an enrollment card which included language directly above his signature stating:

> I certify that I am an active, full-time employee of the above-named employer and work a regularly scheduled work week with such employer. I understand that if I do not meet these requirements I am not eligible for any insurance. I certify that I have read and understood the above provisions.

(F.F. 46, App.)

In mid-November 1985, Cleveland's parent, IC Industries, announced a new fringe benefit package to be effective January 1, 1986, including changes in health insurance, life insurance and prescription insurance (F.F. 48, App. 38a). Decedent left work on November 15, 1985, suffering from terminal cancer, and he never returned to work prior to his death on June 19, 1986. Defendant Smith, who was employed as Cleveland's manager of Employee Benefits and Services, knew decedent was off work suffering from

cancer, so she invited Plaintiff to attend a meeting in Cleveland, Ohio, on November 25, 1985, for the purpose of explaining to her and others the benefit changes which were to be effective January 1, 1986 (F.F. 54, 66, App. 39a, 42a). At that meeting Smith informed those in attendance by a slide presentation of a new group life insurance benefit which would provide for basic company paid life insurance in an amount equal to three times base annual salary plus the opportunity for employees to purchase at group rates life insurance in amounts of one, two or three times base annual salary (F.F. 58, App. 39a). At no time during that meeting nor in the slide presentation nor in any pamphlets distributed at that time was there any mention that the employees had to be "actively at work" before being eligible for the new increased life insurance benefit (F.F. 55, 56, 59, App. 39a, 40a).

At the meeting another glossy, fold-out brochure entitled "Employee Benefits Summary" was distributed to those in attendance, including Plaintiff (Plaintiff's Exhibit 19; F.F. 60, App. 40a). Plaintiff's Exhibit 19 was similar to the brochure which decedent received at the time of his initial employment (Plaintiff's Exhibit 15). It contained an introduction which stated:

> The benefit plans provided for you as a full-time permanent employee of Pneumo Corporation represent an important supplement to your regular earnings. You should know what these plans are and how they work in order to take full advantage of them. This brochure highlights the major provisions of each of the plans as they will be in effect on January 1, 1986.
>
> This summary has been prepared for use as a 'quick' reference source of information about your benefit plans. You may refer to your summary plan descriptions or the official plan documents for more details. Of course, in the event of any conflict between this brochure and the plan documents, provisions of the plan documents will apply.
>
> When you have questions about your benefits that are not answered in the material given to you, please contact the Employee Relations Department.

(F.F. 64, App. 40a-41a)

Under the heading "SURVIVOR SECURITY" the same brochure provided:

> Those who depend on you for support can count on your income while you are actively at work, but there is a need to plan for their continued financial protection in the event of your death. This protection is provided through basic life insurance, supplemental life insurance, ...
>
> *Eligibility*
>
> You are automatically eligible to participate in our life insurance plans on your first day of employment with the Company.
>
> *Cost*
>
> All basic life insurance programs are provided at no cost to you. The Supplemental programs—...—require your contributions.
>
> *Basic Life Insurance*
>
> While actively employed, your basic life insurance benefit will be 3 times your base annual salary, rounded to the next higher $1,000....
>
> *Supplemental Life Insurance*
>
> You may choose to be covered (at your own expense) for an additional amount of insurance equal to one, two, or three times your base annual salary, rounded to the next higher $1,000....

At the meeting of November 25, 1985, Defendant Smith knew decedent was off work suffering from cancer. She knew of the "actively at work" requirement for employees to be eligible for increased life insurance benefits. With that knowledge she distributed enrollment cards and told those in attendance, including the Plaintiff, that the enrollment cards should be signed and returned promptly to Cleveland so that timely arrangements could be made for payroll deductions for premiums and company payment of

premiums in advance of the effective date of the change, January 1, 1986. The off-work employees and their spouses or representative or representatives were directed by Smith to sign and return the enrollment cards, despite Smith's knowledge that the card required the signing employee to certify that he was "an active full-time employee of the above-named employer and work a regularly scheduled work week with such employer." Smith did not inform any of the employees who were off work as of November 25, 1985, or their spouses that they should delay signing and returning their enrollment cards (F.F. 68-70, App. 42a-43a).

On November 26, 1985, decedent selected optional or supplemental life insurance at three times his salary, signed the enrollment card and forwarded it to Cleveland which began payroll deductions in accordance with his selection as of January 1, 1986 (F.F. 73, 128, 136, App. 43a, 53a, 53a-54a). Both the decedent and the Plaintiff, his spouse, believed up until the time of the decedent's death that he was covered under the new life insurance benefit plan and would be entitled to both the basic life insurance in an amount equal to three times his annual salary as well as supplemental life insurance in an amount equal to three times his annual salary (F.F. 207-209, App. 66a-67a).

Cleveland ceased distributing copies of Plaintiff's Exhibit No. 14, the insurance certificate prepared by Hancock titled "Your Group Insurance Plan", in December of 1985 (F.F. 242, App. 71a). Pneumo Corporation, Cleveland's parent, was the plan administrator under ERISA for the group health and life insurance plan funded by the John Hancock policy (F.F. 224, App. 68a). The plan administrator's duties were performed by various individuals such as Defendants Smith and Borah at Cleveland (F.F. 225, App. 68a). Smith testified that effective January 1, 1986, Plaintiff's Exhibit No. 19, the glossy fold-out entitled "Employee Benefits Summary" was considered to be the summary plan description for the benefits described therein, which included group life insurance (F.F. 243, App. 71a).

Following decedent's death Cleveland, through Defendants Smith and Borah, processed a claim application and forwarded the same to John Hancock indicating that Plaintiff was entitled to life insurance benefits under the new plan in the amount of $202,000 consisting of the basic life insurance in the amount of $101,000 and supplemental in the amount of $101,000 (F.F. 156-158, App. 57a). John Hancock denied the claim under the new plan, taking the position that decedent was not actively at work when the plan went into effect January 1, 1986, and was never actively at work thereafter. As a result he was not entitled to the increased benefits, despite the fact that he had paid premiums by payroll deduction for benefits under the new plan beginning January 1, 1986 (F.F. 161, App. 58a). Plaintiff then instituted this action to recover life insurance benefits under the new plan since Plaintiff's Exhibit No. 19, which was considered by the plan administrator to be the summary plan description for life insurance, indicated that the decedent was automatically eligible to participate and set forth absolutely no conditions of eligibility, disqualification or denial or loss of benefits.

The District Court's verdict represents the difference between what Plaintiff would be entitled to by way of life insurance benefits under the new plan ($202,000) and that which she was paid under the old plan ($68,000) (F.F. 174, App. 60a).

ARGUMENT AMPLIFYING REASONS RELIED ON FOR ALLOWANCE OF WRIT OF CERTIORARI

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1. The United States Court of Appeals for the Third Circuit has decided an important question of Federal law which has not been but should be settled by the United States Supreme Court. ERISA is a Federal statute which affects essentially every employer and every employee in this country engaged in interstate commerce. 29 U.S.C. §1003(a) and 29 U.S.C. §1002(11). It is a statute enacted "to protect the interests of employees and their beneficiaries in employee benefit plans." *Firestone Tire and Rubber Company v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989).

Congress, in enacting ERISA, was careful to ensure that beneficiaries and participants received complete, understandable and accurate information in written form describing the plan's requirements concerning eligibility for participation and benefits, and circumstances which may result in disqualification, ineligibility, or denial or loss of benefits. 29 U.S.C. §1022. That information Congress required to be furnished to the participants and beneficiaries by way of a summary plan description ("S.P.D."). The only document which Congress required the plan administrator to furnish to participants and beneficiaries describing the plan including events which would result in disqualification or forfeiture is the S.P.D. Congress felt that disclosure and reporting was important enough to enact very specific mandates for the plan administrator in connection with the duty of disclosure and reporting. 29 U.S.C. §§1021-1030.

The disclosure requirements promote the interest of beneficiaries and participants in their plans as Congress indicated:

> Disclosure has been seen as a device to impart to employees sufficient information and data to enable them to know whether the plan was ... being administered as intended. It was expected that the information disclosed would enable employees to police their plan.

H. R. Rep. No. 93-533, 93rd Cong., 2d Sess., reprinted in 1974 U.S. Code Cong. and Ad. News 4639, 4649.

Congress relied upon the mandate of ERISA to ensure that the millions of participants and beneficiaries in this country to be affected by that statute would be fully informed by plan administrators of their rights and obligations under the plan and especially any incidents which could result in ineligibility, disqualification or forfeiture. Failure of the Federal courts to effectuate ERISA's statutory mandates with regard to disclosure and reporting will result and has, in fact, resulted in Congress's intent with regard to reporting and disclosure being totally frustrated.

The frustration of Congress's intent with regard to disclosure and reporting is especially evident in the result which has occurred in the instant case. For those participants and beneficiaries of ERISA plans residing in the geographical area encompassed by the United States District Court for the Third Circuit, there is absolutely no remedy for the failure of a plan administrator to comply with the ERISA mandate concerning S.P.D.'s. Following the logic and holding of the Third Circuit Court of Appeals in this case to its logical conclusion will result in plan administrators' deciding that their best course is to ignore the statutory requirement of an S.P.D. inasmuch as there is no remedy for that defiance, in violation of ERISA.

In the instant case the group life insurance policy entered into between Cleveland and John Hancock required that John Hancock issue a certificate of insurance describing the life insurance benefit which could then be distributed to all affected employees (F.F. 21, App. 29a-31a). The policy required:

> The Insurer (John Hancock) will issue to the Policyholder for delivery to each insured employee a certificate setting forth a summary of the essential features of the insurance and stating to whom the benefits are payable.

(Exhibit J.H. 1, p. 6)

John Hancock issued such a certificate with respect to the group life insurance benefit under the old plan. This document,

entitled "Your Group Insurance Plan", is identified as Plaintiff's Exhibit 14 (F.F. 27, App. 32a). When John Hancock prepared and distributed Plaintiff's Exhibit 14, it had no reason to know that Cleveland would utilize the "certificate" as an S.P.D. for benefits available under the group life and health insurance policy (F.F. 226, App. 69a). It is clear, as the Court of Appeals found, that the certificate

> ... was not drafted to serve as a summary plan description, and although the certificate included a lengthy description of the terms of the group insurance policy, it lacked most of the other information required by ERISA.

924 F.2d at 1312

For the new benefits package which was to go into effect January 1, 1986, John Hancock did not issue to the plan administrator for delivery to each insured employee the certificate required by the insurance policy setting forth a summary of the essential features of the insurance and stating to whom benefits were payable (F.F. 79, App. 44a). Cleveland, the plan administrator, stopped distributing Plaintiff's Exhibit 14 in December of 1985, obviously, because a new benefits plan was to go into effect January 1, 1986, and it had caused its own summary of benefits to be prepared for distribution to employees (Plaintiff's Exhibit 19).

Defendant Marjorie Smith was employed by the plan administrator as the Benefit Administrator at its Cleveland office. She is the person who was called to the plan administrator's main office in Boston in mid-November 1985, to receive information concerning the new benefits plan (F.F. 48-51, App. 38a). Smith was given, while in Boston, sufficient quantities of Plaintiff's Exhibit 19 to be distributed to all of the employees at the Cleveland plant. She testified unequivocally that she considered the old certificate (Plaintiff's Exhibit 14) to be the S.P.D. for group life insurance benefits prior to January 1, 1986. She then testified that after December of 1985, the S.P.D. for group life insurance was Plaintiff's Exhibit 19. (See cross-examination of Marjorie Smith, pp. 29-30.)

The Court of Appeals found that Plaintiff's Exhibit 19 was not a summary plan description for three reasons. First, it says that because in introductory language there is a "disclaimer" which refers readers to official plan documents and summary plan descriptions for more details, the drafter could not have intended Plaintiff's Exhibit 19 to be the S.P.D. It cites in support of that conclusion a single pre-ERISA decision, to wit, *Anthony v. Ryder Truck Lines*, 611 F.2d 944 (3d Cir. 1979). The difficulty with the Third Circuit's approach is that there was no other S.P.D. for the group life insurance benefit, and the plan administrator, through its agent Smith, testified that Plaintiff's Exhibit 19 was indeed the S.P.D. for group life insurance benefits.

Second, the Court of Appeals reiterated the 12 categories of information which must be in the S.P.D. pursuant to 29 U.S.C. §1022(b). It then concludes that since Plaintiff's Exhibit 19 lacked much of that information, it could not be an S.P.D. This holding is circuitous and further frustrates Congress's intent. Congress required the plan administrator to issue an S.P.D. containing very specific information. If the S.P.D. is issued and distributed by the plan administrator but does not fully comply with the congressional mandate concerning content, the Third Circuit relieves the plan administrator from any consequences of its failure to comply by holding that the document, therefore, is not an S.P.D. The holding should have the effect of encouraging plan administrators to issue and distribute S.P.D.'s which do not contain the required information or to decline to issue any S.P.D. at all. The more logical approach and that which would foster Congress's intent would be to hold that although lacking all of the required information, the document which the plan administrator calls the S.P.D. and distributes as such should be considered by the courts to be the S.P.D. for the benefits involved, and participants' rights and remedies should not be adversely affected by the plan administrator's negligence. See, *Kochendorfer v. Rockdale Sash and Trim Co., Inc.*, 653 F. Supp. 612 at 615 (N.D. Ill. 1987). The Third Circuit cited *Etherington v. Bankers Life and Casualty Company*, 747 F. Supp. 1269 (N.D. Ill.

1990), in support of its finding. In *Etherington*, however, there were in existence other documents which met the ERISA requirements as far as being official plan documents. *Etherington, supra*, 747 F. Supp. at 1276-1277. The *Etherington* Court, as well as the Third Circuit Court of Appeals in the instant case, both relied on *Alday v. Container Corporation of America*, 906 F.2d 660 (U.S.C.A. 11th Cir. 1990). *Alday* actually supports Plaintiff's contention in the instant case inasmuch as there was a very specific S.P.D. which communicated the essentials concerning the plan to the participants which the court found complied with the requirements of ERISA. *Alday, supra*, 906 F.2d at 662.

Third, the Third Circuit found that Plaintiff's Exhibit 19 could not be an S.P.D. since it contained very perfunctory descriptions of other benefits for which there were S.P.D.'s in existence. The Third Circuit really answered its own concern when it found that for the other plans there were specific S.P.D.'s, but for the group life insurance benefit there was none.

Finally, the Court found that Plaintiff's Exhibit 19 was just an updated version of Plaintiff's Exhibit 15, which was not a summary plan description. The conclusion really begs the question inasmuch as the plan administrator specifically intended that Plaintiff's Exhibit 19 be the S.P.D. and the "certificate" was essentially rescinded and no longer distributed.

Nowhere does the Third Circuit Court of Appeals deal with the congressional mandate that employees be provided with an S.P.D. It is one thing to assert that benefits brochures are not S.P.D.'s, but the more difficult situation is to consider the result of the finding that the employer issued no S.P.D. in direct violation of the congressional mandate. The Third Circuit finds that there is no remedy available to an employee who relies on representations contained in an employee benefits summary when there is no S.P.D. The employer, therefore, is at liberty, according to the Third Circuit, to do one or both of two things. First, the employer can issue employee benefit brochures with absolutely no concern as to their accuracy. Second, and more important, the plan administrator is free

to ignore the congressional mandate and issue no S.P.D. at all, therefore, depriving the employee of the ability to "police" his plan as Congress required. This is a conclusion which is incredibly important to plan administrators, employers and millions of workers in this country. The only mechanism provided in ERISA by Congress for participants to learn of the content of their plan is the S.P.D. The Third Circuit has so emasculated that mandate that it is of no effect. Employees are now worse off than before, inasmuch as they must "guess" as to whether or not a particular benefit brochure is accurate, whether it is an S.P.D., and in many circumstances will not be afforded any brochure at all and will be left with absolutely no knowledge of their employee benefit plans.

The United States Supreme Court has rendered no decisions concerning the mandate that plan administrators provide participants with S.P.D.'s. It has decided no case dealing with the question of what will or will not be considered an S.P.D. Further, it has decided no case dealing with the issue of what the consequences will be to the plan administrator of failing to issue an S.P.D. at all. The instant case and issues raised therein will provide the vehicle for this Court to decide these extremely important issues in the context of a case where the facts are essentially undisputed.

2. The United States Court of Appeals has in this case decided an important question of Federal law in a way that conflicts with a decision of another United States Court of Appeals.

The Third Circuit Court of Appeals in the instant case relied heavily upon its decision in *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155 (U.S.C.A. 3d Cir. 1990). The *Hozier* case concerned employees' claims for severance payments when involuntarily terminated. The plaintiffs in *Hozier* argued, among other things, that a plan administrator's amendment was invalid because of the failure to comply with an ERISA disclosure and reporting requirement similar to the S.P.D. requirement. *Hozier, supra*, 908 F.2d at 1166-1167. In *Hozier* as well as in the instant case, the Third Circuit Court of Appeals held that a participant's only remedy for a reporting and disclosure violation is that available under 29 U.S.C. §1132(a)(1)(A).

That section refers to 29 U.S.C. §1132(c), which affords a remedy only for a failure on the part of the plan administrator to provide requested information.

That remedy has been characterized by the United States Court of Appeals for the Ninth Circuit as essentially no remedy at all. In *Blau v. DelMonte Corporation*, 748 F.2d 1348 (U.S.C.A. 9th Cir. 1985), the Court was confronted with a case where DelMonte Corporation did not disclose to employees a separation allowance policy. The *Blau* Court noted the failure of DelMonte to comply with ERISA's mandatory reporting and disclosure requirements. What the *Blau* Court said concerning DelMonte's conduct could be applied with equal force to the plan administrator's conduct in the instant case. The Ninth Circuit noted:

> There was no summary plan description, no claims procedure, and no provision to inform participants in writing of anything. DelMonte's claims procedure fails simply because there was none.

Blau, supra, 748 F.2d at 1353.

The Court went on to note that where there are clear violations of reporting and disclosure requirements, the remedy afforded under 29 U.S.C. §1132(c) "has often been less than satisfactory." *Id.* The *Blau* Court continued to note the importance which Congress placed upon the disclosure and reporting requirements and, further, the importance which Congress placed upon the requirement that plans be in writing and the essential elements thereof be communicated to participants by way of the S.P.D. The Ninth Circuit, in fashioning a remedy for the DelMonte employees, noted:

> ERISA seeks 'to safeguard the well-being and security of working men and women and to *apprise them of their rights and obligations under any employee benefit plan.*' (Emphasis added.)

Blau, supra, 748 F.2d at 1356.

The Third Circuit in the instant case found that even if Plaintiff's Exhibit 19 was a summary plan description, the Plaintiff

could recover nothing thereunder inasmuch as ERISA affords no remedy to a participant to recover benefits under the terms of inaccurate or unlawful S.P.D. Again, the Third Circuit's decision in the instant case does nothing to promote Congress's intent that plan administrators provide participants and beneficiaries with complete, accurate and comprehensive information. The Third Circuit concludes that the only remedy available for disclosure and reporting violations is that afforded by 29 U.S.C. §1132(c), which, for a person in Plaintiff's situation, is no remedy at all. The reasoning of the Ninth Circuit in *Blau* is consistent with the stated intention of Congress, to protect the interests of participants and beneficiaries in their plans. It is consistent with the expressed intention of Congress to require disclosure and reporting so that employees will be in a position to police their plans. It is consistent with Congress's expressed intent that all plans under ERISA will be in writing so that oral modifications and representations will be invalid. *Musto v. American General Corp.*, 861 F.2d 897, 910 (6th Cir. 1988), cert. denied, U.S. , 109 S.Ct. 1745, 104 L.Ed. 2d 182 (1989).

The Ninth Circuit Court of Appeals in *Blau* chose to find under ERISA a remedy for a violation of reporting and disclosure requirements that is meaningful to the participant or beneficiary. The United States Court of Appeals for the Third Circuit in the instant case and in *Hozier* felt constrained to deny such a remedy. This is a conflict which poses a question of great significance and importance for the working men and women of this country and also for plan administrators and consultants writing S.P.D.'s inasmuch as all should be aware of what remedy is provided under ERISA for reporting and disclosure violations.

3. The United States Court of Appeals for the Third Circuit has decided a Federal question of great importance which has not been but should be settled by this Court.

The Court of Appeals in the instant case found that even if Plaintiff's Exhibit 19 was an S.P.D. and even if it was inaccurate, the only remedy available was under 29 U.S.C. §1132(a)(4) and (c). Section 1132(a)(4) permits the Secretary or a participant or benefi-

ciary to seek relief in the event of a violation of 29 U.S.C. §1025(c). Section 1025(c) relates to the administrator's requirements to register under the Internal Revenue Code and has nothing to do with the facts and claims in the instant case. Section 1132(c) subjects an administrator who refuses to comply with a request for information to certain penalties. Again, that remedy has nothing to do with the facts and claims in the instant case.

The Third Circuit's decision has rendered certain remedial provisions of ERISA totally meaningless. Section 1132(a) states:

> **Persons empowered to bring a civil action.** A civil action may be brought— ...
>
> (3) By a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to *redress* such violations or (ii) to enforce any provisions of this title or the terms of the plan.... (Emphasis added.)

In 1985 this Court decided *Massachusetts Mutual Life Insurance Company v. Russell*, 473 U.S. 134, 87 L.Ed. 2d 96, 105 S.Ct. 3085 (1985). In that case the Court found that various extra-contractual damages for breach of fiduciary duty were not recoverable under ERISA. Justice Brennan was joined by Justice White, Justice Marshall and Justice Blackmun in a concurring opinion dealing specifically with remedies available under ERISA. In that concurring opinion, Justice Brennan wrote that he agreed with the majority in its decision limiting breach of fiduciary duty claims to damages which would inure to the benefit of the plan only. What is significant in terms of the Third Circuit's decision in this case with respect to Plaintiff's remedy for violation of the plan is Justice Brennan's statement:

> I agree with the Court's decision today that §409 is more fairly read in context as providing 'remedies that would protect the entire plan' rather than individuals ... and that participants and beneficiaries accordingly must look elsewhere in ERISA for personal relief. Indeed, since §502(a)(3) [29 U.S.C.

> §1132(a) (3)] already provides participants and beneficiaries with 'other appropriate relief ... to redress [ERISA] violations' there was no reason to construe §409 expansively in order to bring these individuals under the penumbra of 'equitable or remedial relief.'

473 U.S. at 150, 87 L.Ed. 2d at 108.

Justice Brennan went on to note:

> Accordingly, we save for another day the questions (1) to what extent a fiduciary's mishandling of a claim might constitute an actionable breach of the fiduciary duties set forth in §404(a), and (2) the nature and extent of the 'appropriate equitable relief ... to redress' such violations under §502(a)(3).

473 U.S. at 150, 87 L.Ed. 2d at 109.

The Plaintiff's argument in the context of §1132(a)(3) is as follows. First, it is clear that the plan administrator violated an ERISA mandate by either not issuing an S.P.D. (pursuant to the holding of the Third Circuit in this case), or issuing an S.P.D. which was inaccurate in that it did not apprise participants and beneficiaries of circumstances which could result in disqualification, ineligibility or denial or loss of benefits.

In either case, the plan administrator violated a provision of ERISA. The civil enforcement section, §1132(a)(3), gives to the beneficiary, the Plaintiff in this case, the right to bring a civil action to (A) obtain an injunction or (B) to obtain other appropriate equitable relief to (ii) redress the violation of the Act. The Third Circuit dismisses the Plaintiff's argument by concluding that it could find no equitable theory upon which the Plaintiff could recover.

This is precisely the case where Justice Brennan's questions concerning §1132(a)(3) can be answered by this Court. Certainly, Congress intended to put some "teeth" in the reporting and disclosure requirements of ERISA. It saw reporting and disclosure as important, as indicated herein. Section 1132(a)(3) gives the beneficiary the right to bring a civil action in equity to obtain appropriate relief to redress the plan administrator's violations.

Section 1132(a)(3)(B) authorizes appropriate equitable relief for two purposes. First, Congress authorized a participant or beneficiary to obtain appropriate equitable relief "to redress such violations." The phrase "such violations" refers to "any act or practice which violates any provision of this title or the terms of the plan." 29 U.S.C. §1132(a)(3)(A). Congress chose the word "redress" and one must assume that it used that word knowing its meaning. Redress is defined as "the receiving satisfaction for an injury sustained." *Black's Law Dictionary*, Revised Fourth Edition, West Publishing Company 1968, p. 1444. If Congress intended participants or beneficiaries to receive satisfaction for injuries sustained because of a violation of ERISA or the terms of a plan, certainly it contemplated that it would be necessary for courts to award money damages. If the participant or beneficiary is to be satisfied for an injury because of a violation of the Act or the plan, it is absurd to suggest that Congress did not intend that redress would include money damages.

Congress also authorized appropriate equitable relief to enforce provisions of the Act or terms of the plan. 29 U.S.C. §1132(a)(3)(B)(ii). This is the language which would seem to authorize equitable remedies in the nature of injunctive relief, removal of trustees, declaratory relief, etc. The statutory scheme, when carefully analyzed, authorizes equitable relief to provide to the individual participant or beneficiary redress for a violation of the Act or the plan. It is reasonable to expect that Congress understood in authorizing equitable relief that equity or remedial relief generally includes all the kinds of relief available to restore a plaintiff's losses and also to protect him from future harm. See *Sommers Drug Stores v. Corrigan Enterprises*, 793 F.2d 1456, 1463 (5th Cir. 1986), cert. denied 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed. 2d 837 (1987).

The Supreme Court has recognized and held that a court in equity may award monetary restitution as an adjunct to injunctive relief. *Tull v. United States*, 481 U.S. 412, 424, 95 L.Ed. 2d 365, 377, 107 S.Ct. 1831, (1987). In enacting ERISA, Congress took away from the states and citizens of the states, state common law actions and remedies with respect to ERISA-covered employee benefit

plans. Congress provided a remedy to individual participants and beneficiaries for equitable relief to redress violations of the Act or employee benefit plans. Congress enacted that statute against hundreds of years of chancery or equitable court jurisdiction which clearly authorizes an award of money damages to satisfy individuals for injuries sustained in the context of traditional equity causes of action.

In its brief to the Third Circuit Court of Appeals, the plan administrator cited a series of cases rejecting that extracontractual monetary damages are available under Section 1132(a)(3).[1] None of the cases cited by the plan administrator hold that the damages sought by the beneficiary in this case are not recoverable under Section 1132(a)(3). The damages sought by the claimants in the cases cited by the plan administrator and referred to hereinabove are of a different quality than damages sought by the beneficiary in the instant case. In the instant case, the beneficiary is seeking redress for the unlawful act of the plan administrator in publishing and distributing a summary plan description which on its face indicated that life insurance benefits were available to the decedent in the amount of $202,000. Even though the policy of life insurance contained a condition which the decedent did not meet, i.e., actively at work, the summary plan description delivered to the decedent deleted that condition and, therefore, violated ERISA's mandate of full disclosure concerning conditions of eligibility and circumstances which may disqualify. Congress contemplated that equitable actions would be brought by participants and beneficiaries for redress for violations of the Act and plans and that courts would, as they have

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[1] *Drinkwater v. Metropolitan Life Insurance Company*, 846 F.2d 821 (1st Cir. 1988), cert. denied 109 S.Ct. 261, 102 L.Ed. 2d 249 (1988); *Powell v. Chesapeake and Potomac Telephone Company*, 780 F.2d 419 (4th Cir. 1985), cert. denied 476 U.S. 1170, 106 S.Ct. 2892, 90 L.Ed. 2d 980 (1986); *Sommers Drug Stores v. Corrigan Enterprises*, 793 F.2d 1456 (5th Cir. 1986), cert. denied 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed. 2d 837 (1987); *Varhola v. Doe*, 820 F.2d 809 (6th Cir. 1987); *Kleihans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618 (7th Cir. 1987); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986); *Bishop v. Osborn Transportation, Inc.*, 838 F.2d 1173 (11th Cir. 1988), cert. denied 109 S.Ct. 90, 102 L.Ed. 2d 66 (1988).

always done, on occasion award monetary damages in the context of an equity action.

Equity courts do not and have not traditionally awarded damages such as those for mental and emotional distress, punitive damages, damage to one's marriage, etc. This is especially so, as many of the above cases point out, in dealing with actions of trustees. The beneficiary in the instant case is not seeking damages of the quality of punitive damages or compensatory damages for mental or emotional distress, but, rather, is seeking, very simply, contractual damages based upon the employee benefit plan as evidenced by the summary plan description. She is not seeking and was not awarded extra-contractual damages, but, rather, damages based strictly upon the terms and conditions of the summary plan description itself. This is precisely the remedy which Congress provided and one which is consistent with the holding of the Supreme Court in *Russell*.

The decedent in this case received in late November 1985, Plaintiff's Exhibit 19, a document characterized by the plan administrator as an S.P.D. He was told in that S.P.D. the following:

> Those who depend on you for support can count on your income while you are actively at work, but there is a need to plan for their continued financial protection in the event of your death. This protection is provided through basic life insurance, supplemental life insurance, ...
>
> *Eligibility*
>
> You are automatically eligible to participate in our life insurance plans on your first day of employment with the Company.
>
> *Cost*
>
> All basic life insurance programs are provided at no cost to you. The Supplemental programs—...—require your contributions.
>
> *Basic Life Insurance*
>
> While actively employed, your basic life insurance benefit will be 3 times your base annual salary, rounded to the next higher $1,000....

Supplemental Life Insurance

You may choose to be covered (at your own expense) for an additional amount of insurance equal to one, two, or three times your base annual salary, rounded to the next higher $1,000....

He was then given an enrollment card by the plan administrator and told that he must sign the card, make his selection with respect to amount of insurance and return it for processing as soon as possible. The enrollment card contained language which indicated that he would only be eligible for increased benefits if he was an active, full-time employee working a regularly scheduled work week (F.F. 73, App. 43a). The plan administrator knew that he was off work suffering from cancer, but, nonetheless, told him that he must sign and return the card, making his selection with respect to amount of insurance (F.F. 67-70, App. 42a). Decedent selected the maximum amount of supplemental insurance, returned his enrollment card and, in fact, up until the time of his death paid premiums for that supplemental insurance under the new plan. Both he and his wife believed up until the time of his death that upon his death she would receive $202,000 of group life insurance benefits. This belief was based upon the representations set forth in Plaintiff's Exhibit 19.

An analysis of the decision of the Third Circuit Court of Appeals in the instant case reveals the following. Congress enacted ERISA, a statute intended to protect and promote the interests of beneficiary and participants in their benefit plans. ERISA preempted all state laws and state and common law causes of action with respect to employee benefit plans covered thereby. ERISA granted to the Federal courts jurisdiction of ERISA claims without benefit of a jury trial. The statute mandates that participants be informed of benefits through one instrument and one instrument only, an S.P.D. containing information which will let employees know clearly, comprehensively and accurately any circumstances of ineligibility or disqualification. Finally, ERISA provides a remedy by way of a civil cause of action for participants and beneficiaries to seek injunctions and/or obtain redress for any violation of the statute.

In the instant case, according to the United States Court of Appeals for the Third Circuit, the plan administrator for the group life insurance benefit issued no S.P.D., in direct violation of ERISA. For that violation the individual participant or beneficiary is afforded no remedy whatsoever. The message, certainly, to plan administrators and employers in the geographical area encompassed within the Third Circuit is that the safest course to follow is to issue no S.P.D. at all inasmuch as participants and beneficiaries have no remedy for that violation. The best thing to do is to act secretively and keep beneficiaries and participants "in the dark" with respect to conditions of disqualification, ineligibility and other circumstances surrounding their plans. This result does anything but further the interests of participants and beneficiaries in their plans, is directly violative of the statute itself, and is violative of the holding of the Supreme Court in *Firestone Tire and Rubber Co. v. Bruch, supra.*

The more logical approach and that which furthers the intention of Congress in enacting ERISA in the first place is to be found in the decision of District Court Judge Muir wherein he found:

> For the plan which became effective January 1, 1986, Cleveland considered Plaintiff's exhibit No. 19, entitled 'Employee Benefits Summary,' to be the summary plan description. This document in no way complies with ERISA requirements as to ineligibility. The Survivor Security Section of the 'Employee Benefits Summary' states that the employee is 'automatically eligible to participate in our life insurance plans on your first day of employment with the company.' Nowhere in the booklet is there any statement of circumstances which may result in disqualification or ineligibility for benefits. The only restriction placed on the receipt of increased benefits is that the individual be employed with the company. It is undisputed that Mr. Gridley was still an employee with the company from January 1986 until the time of his death.

(Slip opinion, pp. 53-54)

Finally, Judge Muir concluded as a matter of law that:

> Decedent met all of the requirements respecting eligibility for participation in benefits as set forth in the Summary Plan

> Description, Plaintiff's Exhibit 19, with respect to both basic and supplemental life insurance coverages and his named beneficiary, Plaintiff herein, is entitled to receive from Cleveland Pneumatic Company those benefits under the Employee Benefit Plan, effective January 1, 1986, in the full amount of $202,000.00.

(Slip opinion, p. 71)

Judge Muir's opinion breathes some life into §1132(a)(3) by affording broad equitable relief to redress the plan administrator's violation of the Act. The Third Circuit's decision, on the other hand, encourages plan administrators to ignore the congressional mandate concerning S.P.D.'s and either keep employees in the dark or misinform them inasmuch as, in either case, the employee has no remedy.

It is really impossible to "square" the Third Circuit's decision in the instant case with its decision in *Genter v. Acme Scale and Supply Company*, 776 F.2d 1180 (U.S.C.A. 3d Cir. 1985), where it held, "[A] summary plan description must not mislead, misinform, or fail to inform participants and beneficiaries of the Plan." In *Genter* the Third Circuit awarded to a beneficiary a life insurance benefit which was available but not disclosed in the S.P.D. The Third Circuit in that case held that:

> ERISA requires that important rights and obligations of employees in any such plan be clearly and fully stated....
>
> One of these methods, the midstream method was never disclosed to the employees in any of the Plan documents, in violation of ERISA, 29 U.S.C. §§1021, 1022.

776 F.2d at 1185.

The Court went on to hold that:

> The failure to provide a clear and plain statement of the Plan description is a violation of ERISA, 29 U.S.C. §1022(a)(1), for which, had the decedent known, he could have considered the midstream increase option that other employees exercised.... It is the employee's right to be informed of his rights however, rather than the wisdom of the employee's decision concerning these rights that the Act is intended to protect.

> Whether he would have opted for more coverage is not necessary for us to consider. What is necessary to consider is the circumstance that his beneficiary has been denied the additional $10,000 of coverage that the decedent could have provided for her had he been properly informed.

776 F.2d at 1186.

In *Genter* there was a failure to accurately inform employees of a method of increasing life insurance coverage. The claim is identical to the claim made by the beneficiary in the instant case. In *Genter* there is a finding as a matter of law that the administrator violated ERISA in failing to provide an accurate summary plan description, just as there is such a finding in the instant case. In *Genter* the Court ordered that judgment be entered in favor of the plaintiff for the difference between the insurance coverage that was, in fact, in place and that which was available under the plan which was not disclosed to employees, just as the trial court awarded in the instant case. The decision in *Genter* is consistent with the decision of the trial court in this case and is consistent with ERISA, which affords such a remedy to individual participants or beneficiaries who are the victims of inaccurate summary plan descriptions.

It is incomprehensible that Congress would enact a statute intended to protect employees and beneficiaries and to mandate complete and accurate disclosure concerning the administration and content of plans and yet afford no remedy to the intended beneficiaries of the Act for failure of plan administrators to comply with the statutory mandate. The trial court's decision in the instant case is grounded upon very specific statutory provisions of ERISA authorizing exactly this type of a civil action for a participant or beneficiary to recover benefits due under the terms of the plan and to secure redress for violations of the Act and the plan itself.

CONCLUSION

For the foregoing reasons, Petitioner prays your Honorable Court grant her Petition for Writ of Certiorari.

Respectfully submitted,
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Filed February 4, 1991

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 90-5262

GLADYS M. GRIDLEY Appellee

v.

CLEVELAND PNEUMATIC COMPANY, a subsidiary of Pneumo Corporation, a subsidiary of IC Industries; MARJORIE ANN SMITH, individually and as Manager of Employee Benefits and Services; PATRICIA BORAH, individually and as Employee Benefits Administrator; JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY

Cleveland Pneumatic Company, a subsidiary of Pneumo Corporation, Appellant

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ON APPEAL FROM THE UNITED STATES
DISTRICT COURT FOR THE
MIDDLE DISTRICT OF PENNSYLVANIA
(D.C. Civil No. 88-00908)

Argued: October 9, 1990

Before: MANSMANN, ALITO and GARTH,
Circuit Judges

(Opinion Filed: February 4, 1991)

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OPINION OF THE COURT

ALITO, *Circuit Judge*

This case concerns a dispute between the Cleveland Pneumatic Company ("Cleveland") and Gladys M. Gridley, the wife of a former Cleveland employee, Joseph Gridley, regarding Mrs. Gridley's entitlement to increased life insurance benefits provided by an amendment to the company's group life insurance plan that took effect after Mr. Gridley ceased active work due to terminal cancer. The district court held that Mrs. Gridley was not entitled to the increased benefits under the terms of the group life policy because Mr. Gridley was never "actively at work" following the date when the increased benefits took effect, as required by the policy terms. The court held, however, that Cleveland was obligated under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et. seq.*, to pay Mrs. Gridley the increased benefits. The court concluded that a

beneficiary may recover benefits due under a summary plan description (*see* 29 U.S.C. § 1022) and that a brochure that was distributed to Cleveland employees at about the time of the new amendment and that generally surveyed employee benefits constituted a summary plan description of the company's life insurance plan. Because this brochure omitted the "actively at work" requirement and contained language that the court believed was inconsistent with this requirement, the court held that Cleveland was obligated to pay Mrs. Gridley the increased benefits.

We conclude that the brochure in question was not a summary plan description and that, even if it were, Mrs. Gridley would not be entitled to recover the increased benefits. Accordingly, we will reverse.

I.

Joseph Gridley began work for Cleveland on May 17, 1985 at an annual salary of $33,500. A few years earlier, Mr. Gridley had been afflicted with lung and brain cancer, but at the time of his employment by Cleveland there was no sign of recurrence. When Mr. Gridley began work, Cleveland gave him a variety of materials describing employee benefits. A glossy brochure containing five fold-out panels and entitled "Employee Benefits Summary" (Plaintiff's Exhibit 15) ("P15") provided an overview of the company's benefit plans. (For convenience, we will refer to this document as the "overview brochure" or the "earlier overview brochure.") The Introduction to this overview brochure (P15) stated that "[t]his brochure highlights the major provisions of each of the [company's benefit] plans" and that it had been prepared "for use as a 'quick' reference

source of information about [the] benefit plans." The Introduction added: "[y]ou may refer to your *summary plan descriptions* or the official plan documents for more details" (emphasis added). In addition, the Introduction warned that "in the event of any conflict between this brochure and the plan documents, provisions of the plan documents will apply." On the fold-out panels following the Introduction, the overview brochure (P15) provided a brief description of the company's benefits regarding medical and dental care, income protection, survivors' security, pensions, and other matters such as vacations, holidays, education reimbursements, funeral leave, military training, and jury duty.

In addition to this overview brochure (P15), Mr. Gridley received several documents that clearly constituted summary plan descriptions within the meaning of ERISA. Plaintiff's Exhibit 20 ("P20"), entitled "Summary Plan Description - Salary Continuance Plan," described the salary benefits initially available for employees who became unable to work due to illness or disability. Similarly, Defendant's Exhibit C-1 ("D-C1"), entitled "Summary Plan Description - Long-Term Disability Plan," summarized the disability benefits available to company employees after the salary continuance benefits were exhausted. These documents contained the information required by the relevant provision of ERISA, 29 U.S.C. § 1022, such as "[the] name and type of administration of the plan," "the name and address of the person designated as agent for the service of legal process," "the name and address of the administrator," "the names, titles and addresses of any trustee or trustees," "the procedures to be followed in presenting claims for benefits," "and

the remedies available under the plan for the redress of claims" that are denied.

With respect to the group insurance plan, which provided life, health, and other insurance benefits, Cleveland did not give Mr. Gridley any document entitled a "summary plan description," but instead furnished a certificate, entitled "Your Group Insurance Plan" ("P14"), that was prepared by the underwriter, John Hancock Mutual Life Insurance Company ("John Hancock") (for convenience we will refer to this document as the "certificate."). This certificate (P14) was not drafted to serve as a summary plan description, and although the certificate included a lengthy description of the terms of the group insurance policy, it lacked most of the other information required by ERISA.

Both the certificate (P14) and the group insurance policy itself contained provisions specifying that an employee became eligible for an increase in insurance benefits only if he was "actually" or "actively" at work after the increase took effect.[1] The group insurance policy stated that an employee "shall not be entitled to any increase in insurance or any additional benefits for which he may be eligible until he actually returns to work." Likewise, the certificate (P14) stated (emphasis added):

> *ACTIVELY AT WORK REQUIREMENT.*
>
> If you are not *actively at work* on the date an increase in benefits would become effective under the Schedules shown herein, such increase will not become effective until the date you return to active work.

---

[1] Neither party has asserted that there is any material difference for present purposes between the meanings of these two phrases.

The certificate (P14) defined "actively at work" to mean that the employee must be able to perform "all of the usual and customary duties of his occupation on a regular, full-time basis."[2]

Unlike the group insurance policy and the certificate (P14), the overview brochure (P15) did not mention the "actively at work" requirement but stated that employees were "eligible to participate in [the company's] life insurance plans on [their] first day of employment with the Company."

Under the life insurance policy, Cleveland paid for basic life insurance coverage for its employees. This basic coverage equalled 150% of their annual salaries rounded to the next higher thousand. Thus, for Mr. Gridley, this basic coverage amounted to $51,000. Cleveland employees could also purchase additional life insurance equal to 50% or 100% of their annual salaries rounded to the next higher thousand. Mr. Gridley elected

---

[2] The complete definition of "actively at work" in the certificate reads as follows:

> "actively at work" - an employee shall be considered "actively at work" if he reports for work on the date in question at his usual place of employment with his Employer and such usual place of employment is outside of his home, and if when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular, full-time basis. If an employee does not so report, or if his usual place of employment with his Employer is not outside of his home, he shall be considered "actively at work" if at any time on the date in question, he is neither (i) hospital confined, nor (ii) disabled to a degree that he could not then have reported to a place of employment outside of his home and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

supplemental life insurance equal to 50% of his salary rounded to the next higher thousand - or $17,000. Thus his total life insurance coverage equalled $68,000. When he applied for the supplemental life insurance, Mr. Gridley filled out a "group optional life insurance enrollment card," which stated directly above his signature:

> I certify that I am an active full-time employee of the above-named employer and work a regularly scheduled work week with such employer. I understand that if I do not meet these requirements I am not eligible for any insurance . . . .

In November 1985, approximately six months after beginning work with Cleveland, Mr. Gridley was diagnosed with a recurrence of cancer. After November 15, 1985, he never again reported to work or performed any work for Cleveland. He died in June 1986. At no time prior to his death did Mr. or Mrs. Gridley inform Cleveland that Mr. Gridley was terminally ill and would not be returning to work.

At approximately the same time when Mr. Gridley left work, IC Industries, the owner of Cleveland's parent company, Pneumo Corporation, decided to improve the group insurance program for Cleveland's employees. Marjorie Smith, Cleveland's Manager of Employee Benefits, set up a meeting to explain the changes to the affected employees. Since Mr. Gridley was not at work, his wife was invited to attend the meeting, which occurred on November 25, 1985. At the meeting, Ms. Smith informed the employees that as of January 1, 1986, basic life insurance benefits would be increased to three times salary and that supplemental life insurance would be made

available in amounts equal to one, two, or three times annual salary rounded to the next higher thousand. During the presentation at the meeting, the "actively at work" eligibility requirement was not mentioned. Moreover, no Cleveland employee ever subsequently reminded Mr. or Mrs. Gridley of this requirement.

At this meeting, Mrs. Gridley received an updated version of the overview brochure that was strikingly similar in appearance and content to the brochure furnished to Mr. Gridley when he began work. (For convenience, we will refer to this document as the "new brochure" or the "new overview brochure".) The Introduction to this new brochure ("P19") stated that it "highlight[ed] the major provisions of each of the plans as they will be in effect on January 1, 1986." Like its predecessor (P15), the new brochure (P19) explained that "[t]his summary has been prepared for use as a 'quick' reference source of information about your benefit plans." The new brochure (P19), like the earlier overview brochure (P15), also advised: "You may refer to your *summary plan descriptions* or the official plan documents for more details. Of course, in the event of any conflict between this brochure and the plan documents, provisions of the plan documents will apply"(emphasis added).

One of the panels of the new brochure (P19), labeled "SURVIVOR SECURITY," contained an explanation of the increased life insurance benefits available after January 1, 1986, but like the description of the life insurance benefits in the earlier overview brochure (P15), the description omitted any reference to the "actively at work" requirement. Employing the same language as the earlier overview brochure (P15), the new overview

brochure (P19) stated: "You are automatically eligible to participate in our life insurance plans on your first day of employment with the Company."

At the meeting on November 25, Mrs. Gridley received an enrollment card for the supplemental insurance. She was instructed that, if Mr. Gridley wanted to obtain these benefits, the card should be signed and returned so that payroll deductions could be processed. The next day, Mr. Gridley completed the card and selected the maximum supplemental life insurance benefits, i.e., three times his salary or $101,000. Together with the $101,000 in basic coverage provided by the company after January 1, 1986, this supplemental coverage would have given Mr. Gridley a total of $202,000 in life insurance coverage. Immediately above the space where Mr. Gridley signed the card, the following language appeared:

> I certify that I am an active, full-time employee of the above-named employer and work a regularly scheduled work week with such employer. I understand that if I do not meet these requirements I am not eligible for any insurance. I certify I have read and understood the above provisions.

After this card was returned and processed, additional amounts were deducted from Mr. Gridley's salary or paid by Mr. Gridley to cover the increase in supplemental insurance coverage.

After leaving work, Mr. Gridley applied for and received benefits under Cleveland's salary continuance and long-term disability plans. In support of these applications, Mr. Gridley's doctor certified that Mr. Gridley was continuously and

totally disabled beginning on November 16, 1985.[3] Mr. Gridley also applied for and was awarded social security disability benefits, with disability commencing on November 15, 1985.

After Mr. Gridley's death, Mrs. Gridley submitted a claim through Cleveland to receive $202,000 in death benefits from John Hancock. John Hancock instead issued a check for the sum of $68,426.26, which represented Mr. Gridley's pre-increase coverage plus interest. With the check, John Hancock sent a letter explaining that "because Mr. Gridley had not been actively at work on January 1, 1986 or any time thereafter [Mrs. Gridley] was not eligible to receive the $202,000 which would have been available under the new plan." The overpaid premiums were refunded to Mrs. Gridley.

In 1988, Mrs. Gridley brought suit against Cleveland, John Hancock, and two Cleveland employees in the Middle District of Pennsylvania, seeking the increased life insurance benefits for which Mrs. Gridley would have been eligible after January 1, 1986. After a non-jury trial, the court entered judgment in favor of Mrs. Gridley and against Cleveland in the amount of $134,000 ($202,000 minus the check previously provided). At the same time, the court entered judgment in favor of the other defendants, John Hancock and the Cleveland employees.

In awarding judgment against Cleveland, the district court held that Cleveland's new overview brochure (P19) constituted a summary plan description within the meaning of ERISA, and the

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[3] At trial, however, Mr. Gridley's physician testified that Mr. Gridley could have returned to work for some period had he realized that this was necessary to qualify for increased life insurance benefits.

court held that the terms of this summary plan description were enforceable against Cleveland. Since the new overview brochure (P19) lacked any explanation of the "actively at work" requirement and indeed stated that employees became eligible to participate in the life insurance plans on the first day of employment, the court held that Cleveland was obligated to pay the new increased benefits.

By contrast, the court concluded that John Hancock was not liable by virtue of the new overview brochure (P19) because John Hancock played no part in drafting or distributing that document. Furthermore, the court held that the Cleveland employees were not liable because they had no discretionary authority to award or deny life insurance benefits and had no affirmative duty to advise the Gridleys of the "actively at work" requirement.

Although the district court accepted Mrs. Gridley's argument that she was entitled to the increased benefits as a result of the allegedly faulty description in the new overview brochure (P19), the court rejected her contention that she was also entitled to the increased benefits under the group life insurance policy itself. Concluding that Mr. Gridley "was not capable of working his regular eight hours per day, five days per week," the court held that he did not meet the "actively at work" requirement set out in the policy and certificate (P14).[4]

Finally, the court held that Mrs. Gridley could not recover under the theory of promissory

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[4] Applying Massachusetts insurance law, the district court held that the certificate was relevant to clarify any ambiguities in the policy.

estoppel. Although the court concluded that Cleveland had misled the Gridleys regarding the "actively at work" requirement, the court held that the Gridleys "were not prejudiced or damaged by their reliance on the actions of Cleveland's employees" because Mr. Gridley could not have actively returned to work even if he had tried.

Cleveland appealed; Mrs. Gridley did not cross-appeal the judgments in favor of John Hancock and the Cleveland employees.

II.

We now consider whether Mrs. Gridley is entitled to recover the increased life insurance benefits under ERISA. Section 502(a) of ERISA, 29 U.S.C. § 1132(a), contains a comprehensive civil enforcement scheme that was "intended to be exclusive." *Pilot Life Insurance v. Dedeaux*, 481 U.S. 41, 54 (1987). *See also Ingersoll-Rand Co. v. McClendon*, 59 U.S.L.W. 4033, 4036 (U.S. Dec. 3, 1990); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 146 (1985); *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1169 (3d Cir. 1990). Mrs. Gridley maintains that she is entitled to recover the increased life insurance benefits under two provisions of this comprehensive enforcement scheme.

A.

First, Mrs. Gridley contends, as the district court apparently held, that she is entitled to recover increased life insurance benefits under Section 502(a)(1)(B), 29 U.S.C. § 1132 (a)(1)(B), which authorizes a "beneficiary . . . to recover benefits due to him under the terms of his plan." Mrs. Gridley maintains that the term "plan" includes a summary plan description, that the new overview

brochure (P19) constituted a summary plan description, and that ERISA therefore authorizes her to "recover benefits due to [her] under the terms of [the brochure]." We reject this argument both because the new overview brochure (P19) was not a summary plan description and because a summary plan description is not a "plan" within the meaning of Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

1. Whether a document constitutes a summary plan description within the meaning of the relevant provision of ERISA, 29 U.S.C. § 1022, involves a determination of "ultimate fact" and is therefore subject to plenary review. *Universal Minerals v. C. A. Hughes,* 699 F.2d 98, 102 (3d Cir. 1981). Applying this standard, we conclude that the new overview brochure (P19) did not constitute a summary plan description. Four chief factors inform our holding. First, the new overview brochure (P19) contains an important internal reference to "summary plan descriptions." *See Anthony v. Ryder Truck Lines,* 611 F.2d 944, 948 (3d Cir. 1979). As previously noted, the Introduction of the new overview brochure (P19) stated: "You may refer to your *summary plan descriptions* or the official plan documents for more details." In light of this language, the drafter or drafters could not have thought, and a reasonable reader could not have concluded, that the new overview brochure (P19) itself was a summary plan description.

Second, the new overview brochure (P19) lacks virtually all of the categories of information required by ERISA for summary plan descriptions. Under 29 U.S.C. § 1022(b), a summary plan description must contain 12 categories of information: (1) the name and type of

administration of the plan, (2) the name and address of the person designated as agent for the service of legal process, (3) the name and address of the administrator, (4) the names, titles and addresses of any trustee or trustees, (5) a description of the relevant provisions of any applicable collective bargaining agreement, (6) the plan's requirements respecting eligibility for participation and benefits, (7) a description of the provisions providing for non-forfeitable pension benefits, (8) the circumstances which may result in disqualification, ineligibility, or denial or loss of benefits, (9) the source of financing of the plan and the identity of any organization through which benefits are provided, (10) the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis, (11) the procedures to be followed in presenting claims for benefits under the plan, and (12) the remedies available under the plan for redress or claims which are denied. The new overview brochure's (P19) description of the life insurance plans, however, lacks any information relating to all but two of these categories, i.e., information relating to eligibility for participation and benefits and information concerning the source of financing. *See Alday v. Container Corp. of America*, 906 F.2d 660, 665 (11th Cir. 1990) ("Summary of Benefits Booklet" that lacked much of the information required by 29 U.S.C. § 1022 was not summary plan description); *Etherington v. Bankers Life & Casualty Co.*, 747 F.Supp. 1269, 1276-77 (N.D. Ill. 1990) ("Group Insurance Benefits Booklets" that lacked information required by 29

U.S.C. § 1022(b) was not a summary plan description).[5]

Third, the new overview brochure (P19) contains extraordinarily perfunctory descriptions of subjects treated in other company documents that unquestionably constituted summary plan descriptions. As previously noted, when Mr. Gridley began work he was given a 12-page summary plan description regarding the company's salary continuance plan ("Summary Plan Description - Salary Continuance Plan") (P20) and another 12-page summary plan description regarding the long-term disability plan ("Summary Plan Description - Long-Term Disability Plan") (D-C1). These plans, which apparently did not change on January 1, 1986, when the life insurance benefits increased, were also discussed in the new overview brochure (P19), but this entire discussion consisted of the following three sentences:

> Depending on your location and salary classification, a portion of your salary will be continued during certain periods of disability. The provisions of the plans prior to January 1, 1986 remain in effect. Consult your Summary of Benefits for the benefits that apply to you.

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[5] The document at issue in this case (P19) is readily distinguishable from the document held to be a summary plan description in *Kochendorfer v. Rockdale Sash & Trim Co., Inc.*, 653 F.2d 612 (N.D. Ill. 1987), upon which Mrs. Gridley relies. In that case, the document in question did not "indicate that it is not a summary plan description, or state that another document will govern if inconsistencies exist" (*id.* 616). Here, as previously noted, the new overview brochure (P19) contains a cross-reference to the company's summary plan descriptions and states clearly that the plan controls in the event of any inconsistencies.

If we held that the new overview brochure (P19) constituted the summary plan description for all the plans it summarized (not only the insurance plans but also the salary continuance and long-term disability plans), we would be holding that the company replaced its detailed summary plan descriptions for the salary continuance and long-term disability plans with the patently inadequate three-sentence description set out above and that the company made this replacement even though the salary continuance and long-term disability plans had not changed and there was consequently no apparent need to update or revise the existing summary plan descriptions for those plans. We cannot accept this unnatural interpretation of the new overview brochure (P19). Nor can we accept the equally unnatural alternative interpretation that that document constituted a new summary plan description for the insurance plans but not for the other plans that it surveyed in like fashion.

Finally, the new overview brochure (P19) was plainly an updated version of the earlier overview brochure (P15), which was not a summary plan description. As already noted, when Mr. Gridley received the earlier overview brochure (P15) at the beginning of his employment, he was also given summary plan descriptions for some of the company's plans. In light of these detailed documents, there can be no doubt that the cursory descriptions of the same plans in the earlier overview brochure (P15) did not constitute the summary plan descriptions for those plans. The new overview brochure (P19) is remarkably similar to its predecessor in content, format, and appearance and clearly represents a modified version of the earlier overview brochure (P15) that

was prepared to incorporate the insurance changes taking effect on January 1, 1986. Thus, since the earlier overview brochure (P15) was not a summary plan description, the same conclusion almost certainly must apply to the new overview brochure (P19) as well.

The district court held that the new overview brochure (P19) constituted the summary plan description for the life insurance plan after January 1, 1986, for essentially two reasons. First, the court seems to have placed great weight on the fact that Cleveland stopped giving new employees the insurance certificate (P14) when it began distributing the new overview brochure (P19). From this sequence of events, the court appears to have inferred that the new overview brochure (P19) replaced the certificate (P14), but in fact it is apparent that the new overview brochure (P19) replaced the earlier overview brochure (P15). As noted earlier, when Joseph Gridley began work in May 1985, he was given both the earlier overview brochure (P15) and the certificate (P14). At the end of 1985, when those documents had become outdated because of changes in the life insurance plan, the company apparently stopped distributing both of them and began distributing the new overview brochure (P19). In light of the striking similarities between the two brochures, it is abundantly clear that the new overview brochure (P19) replaced the earlier overview brochure (P15), and that neither constituted the summary plan description for any of the company's plans.

The district court also found that Cleveland considered the new overview brochure (P19) to be the summary plan description for the insurance plans after January 1, 1986. Although the district court did not specify the basis for this finding,

Mrs. Gridley defends this finding by pointing to testimony by Marjorie Smith, the Benefits Administrator at the company's Cleveland, Ohio, office. On cross-examination, Ms. Smith stated that after the company stopped distributing the certificate (P14) she considered the new overview brochure (P19) to be the summary plan description for life insurance. While this testimony regarding the opinion of a relevant Cleveland employee was certainly entitled to some weight, we believe that this cross-examination testimony alone was plainly insufficient to show that the new overview brochure (P19) was a summary plan description.

2. Even if the new overview brochure (P19) was a summary plan description, Mrs. Gridley was still not entitled to recover increased benefits under Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), which authorizes a beneficiary to receive benefits due "under the terms of [the] plan." Mrs. Gridley contends (Brief at 22) that "there is no definition in ERISA for the word 'plan' " and that the term should be construed to include a summary plan description. Contrary to Mrs. Gridley's assertion, however, ERISA does contain a definition of the term "plan." In Section 3(3), 29 U.S.C. § 1002(3), the term "plan" is defined as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." This definition clearly does not encompass a summary plan description, and accordingly Mrs. Gridley cannot recover under 29 U.S.C. § 1132(a)(1)(B) for benefits allegedly due under a summary plan description.[6]

[6] Contrary to Mrs. Gridley's argument, the district court's decision is not supported by *Genter v. Acme Scale & Supply Co.*, 776 F.2d 1180 (3d Cir. 1985). Whereas the district court in this case awarded Mrs. Gridley increased insurance benefits

B.

In the alternative, Mrs. Gridley contends that she is entitled to recover increased insurance benefits under Section 502(a)(3). 29 U.S.C. § 1132(a)(3), which permits a beneficiary "to obtain . . . appropriate equitable relief . . . to redress [violations of ERISA] or . . . to enforce any provisions of [ERISA] or the terms of the plan."[7] Cast in its best terms, Mrs. Gridley's argument with respect to this provision is as follows: the new overview brochure (P19) was a defective summary plan description and thus violated the provision of ERISA, Section 102(b), 29 U.S.C. § 1022(b), specifying what a summary plan description must contain; Mrs. Gridley is therefore entitled to "appropriate equitable relief" to redress this violation; "appropriate equitable relief" in this case consists of the increased life insurance benefits. This argument, however, also fails.

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that were not available under the life insurance plan itself, *Center* awarded increased life insurance benefits that were provided by the life insurance plan. Under the life insurance plan in *Center*, the employee in question became eligible for increased coverage at company expense when he received a salary in January 1982. He was led to believe that he could not actually obtain the increased coverage until March 1983, and he died in January 1983. This court held, however, that the company's insurance plan provided a second method for obtaining increased coverage more quickly (*id.* at 1185). Because the deceased employee had been improperly denied the opportunity to take advantage of this method, this court held that the employee's widow was entitled to the increased benefits provided by the plan.

[7.] Because this argument presents a question of statutory construction, we exercise plenary review. *See, e.g., Chrysler Credit Corp. v. First National Bank and Trust Co.*, 746 F.2d 200, 202 (3d Cir. 1984).

As previously discussed, the new overview brochure (P19) was not a summary plan description and thus did not violate the provision of ERISA specifying what a summary plan description must contain, Section 102(b), 29 U.S.C. § 1022(b). Moreover, even if that document were a defective summary plan description, payment of increased life insurance benefits would not constitute appropriate equitable relief. Mrs. Gridley has not identified any equitable doctrine other than promissory estoppel under which she could recover increased life insurance benefits, but it is apparent that Mrs. Gridley cannot recover under the theory of equitable estoppel.

Our precedents indicate that an ERISA reporting or disclosure violation, such as the distribution of an inaccurate summary plan description, cannot provide a basis for equitable estoppel, at least in the absence of "extraordinary circumstances." In *Hozier v. Midwest Fasteners,* 908 F.2d at 1166-71, we considered the remedies available for violations of ERISA's reporting and disclosure provisions, Sections 101-111, 29 U.S.C. § 1021-1031. We noted (908 F.2d at 1167) that "ERISA contains two express causes of action to remedy reporting and disclosure violations as such," Sections 502(a)(4) and (c), 29 U.S.C. § 1132(a)(4) and (c). Declining to tamper with ERISA's comprehensive civil enforcement scheme, we held that the reporting and disclosure violations at issue were irrelevant in determining entitlement to benefits. *See also Berger v. Edgewater Steel Co.*, 911 F.2d 911, 921 (3d Cir. 1990). We also noted (*Hozier*, 908 F.2d at 1165 n. 10) that under our precedents equitable estoppel is not available in ERISA cases absent "extraordinary circumstances."

We see no such "extraordinary circumstances" in the present case. Mrs. Gridley asserts what is at best an ordinary equitable estoppel claim. Just as the *Hozier* court found that an alleged "implied representation" that went beyond the terms of the plan did not "colorably" present any "extraordinary circumstances" (908 F.2d at 1165 n. 10), we find no such circumstances present here. Indeed, as the district court held, the present case does not even satisfy the ordinary elements of the doctrine of equitable estoppel.

In order to prevail under that doctrine, a party must show (1) a material representation, (2) reasonable reliance upon that representation, and (3) damage resulting from that representation. *Pane v. RCA Corp.*, 868 F.2d 631, 638 (3d Cir. 1989).[8] Here, the district court found that the Gridleys were not prejudiced or damaged by their reliance on the actions of Cleveland employees, and we cannot conclude that this finding was clearly erroneous. As the district court noted, Mr. Gridley would not have been eligible for increased benefits unless he was "actually" or "actively" at work after January 1, 1986. Under the group insurance plan, as the district court held, an employee is not "actually at work" or "actively at

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[8] The First Circuit has held that a beneficiary or participant who fails to show detrimental reliance upon a misleading summary plan description may not recover under ERISA. *Bachelder v. Communications Satellite* Corp., 837 F.2d 519, 523 (1st Cir. 1988). *See also McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566, 1570 (11th Cir. 1985). The Sixth Circuit has held that detrimental reliance is not needed. *Edwards v. State Farm Mutual Auto Ins. Co.*, 851 F.2d 134, 137 (6th Cir. 1988). Because this latter decision is inconsistent with our precedents (*see, e.g., Pane v. RCA Corp.* 868 F.2d at 638) and finds no support in ERISA's civil enforcement provisions or in the doctrine of equitable estoppel, we decline to follow it.

work" unless he is able to perform all of the "usual and customary duties of his occupation on a regular, full-time basis," and there is strong evidence that Mr. Gridley could not have met this requirement. In support of Mr. Gridley's application for salary continuance and long-term disability benefits, his physician twice certified that Mr. Gridley was "continuously and totally disabled" from "11/16/85 through indefinite." On this certification, Mr. Gridley's physician also listed the date on which Mr. Gridley would be able to return to work as "indefinite." Mr. Gridley himself stated on his application for long-term benefits that he was suffering from a long list of disabling symptoms.[9] Mr. Gridley also disclosed that his physician had imposed the following restrictions on his activities: "no lifting, no driving car, not to go upstairs." Mr. Gridley's job, however, required both that he climb stairs and that he occasionally lift objects weighing up to 40 pounds. The evidence at trial also showed that in early December 1985 the Gridleys vacated their apartment in Cleveland, surrendered their lease, and returned to Wellsboro, Pennsylvania, where Mr. Gridley was hospitalized for some time. These facts amply support the district court's finding that Mr. Gridley could not have performed the "usual and customary duties of his occupation on a regular, full-time basis" after January 1, 1986. It is true, as the district court recognized, that Mr. Gridley's physician testified that Mr. Gridley could have returned to work for some period had he

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[9] Mr. Gridley stated that he was suffering from "extreme fatigue and shortness of breath upon any slight exertion, very weak, bouts of nausea, discomfort and abdominal and right back kidney region pain, phlebitis in legs with difficulty in sleeping nights, difficulty concentrating, difficulty eating and continual weight loss."

realized that this was necessary in order to obtain increased life insurance benefits. But as the district court observed, Mr. Gridley could not have satisfied the "actively at work" requirement simply by returning to work; he was instead required to be able to perform his "usual and customary duties . . . on a regular, full-time basis." Mrs. Gridley argues that the plan administrator would have considered that Mr. Gridley was "actively at work" if he had returned to his job for even a single day after January 1, 1986. The district court correctly held, however, that this interpretation of the "actively at work" requirement is inconsistent with the plan and the interpretation of the underwriter.

Mrs. Gridley contends that the deficient explanation of eligibility for increased benefits in the new overview brochure (P19) deprived her husband of the opportunity to try to satisfy the "actively at work" requirement. In light of the district court's finding that Mr. Gridley was not physically capable of satisfying that requirement, however, this argument is beside the point. Mrs. Gridley also maintains that if her husband had understood the "actively at work" requirement, he could have asked John Hancock for a waiver. But since there is no apparent reason why John Hancock would have been any more willing to grant such a waiver prospectively rather than retrospectively, this argument too must be rejected. Finally, Mrs. Gridley contends that her husband might have been capable of performing the duties of a less demanding job with Cleveland after January 1, 1986, if he had understood the "actively at work" requirement. This argument, which was not addressed by the district court, appears inconsistent with the "actively at work"

requirement, which requires that an employee be able to perform the "usual and customary duties of his occupation," and in any event this argument is insufficient to undermine the district court's finding that Mr. Gridley was incapable of returning "actively" to work.[10]

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[10] Because the requirement of detrimental reliance was not satisfied in this case, we need not decide whether the other elements of equitable estoppel were met. Nevertheless, we note that satisfaction of the remaining elements is problematic. First, it is not clear that the new overview brochure (P19) contained a misrepresentation, as the doctrine of equitable estoppel requires. Mrs. Gridley asserts that that document contradicted the "actively at work" requirement by stating that an employee was "automatically eligible to participate in [the company's] life insurance plan on [the] first day of employment with the Company." It is not apparent, however, that this statement relates to the "actively at work" requirement, which concerns an employee's eligibility for increased benefits. The statement in the new overview brochure (P19) may instead address a *new* employee's eligibility to participate in the insurance plans. Because a new employee will almost invariably be "actively at work" on his "first day of employment with the Company," it is not clear that the statement in that document is inconsistent with the actively at work requirement.

Moreover, it is unclear that it was reasonable for the Gridleys to rely on the new overview brochure (P19) or the failure of the Cleveland employees to remind them of the actively at work requirement. Not only was the actively at work requirement clearly set out in the certificate (P14), which Mr. Gridley received only six months before he became ill, but the very same description of eligibility contained in the new overview brochure (P19) had also appeared in the earlier overview brochure (P15), which was distributed together with the certificate (P14). Accordingly, it is unclear that the reiteration of the same description of eligibility in the new overview brochure (P19) provided reasonable grounds for believing that the "actively at work" requirement had been changed. Finally, we note that Mr. Gridley was required to certify in his applications for supplemental life insurance that he was actively at work and was a regular, full-time employee.

III.

In conclusion, we hold that Mrs. Gridley is not entitled to recover increased life insurance benefits under any provision of ERISA's comprehensive civil enforcement scheme. Accordingly, the judgment of the district court will be reversed.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA
GLADYS M. GRIDLEY, Plaintiff

vs.

CLEVELAND PNEUMATIC COMPANY, A subsidiary of PNEUMO CORPORATION, a subsidiary of IC INDUSTRIES, et al., Defendants

Civil No. 88-0908

Complaint Filed 6/15/88

(Judge Muir)

FILED FEB 21 1990

DONALD R. BERRY, Clerk

Per bp

DEPUTY CLERK

OPINION

MUIR, District Judge.

I. Introduction.

On September 8, 1988, Gladys M. Gridley (Gridley) filed a second amended complaint against Cleveland Pneumatic Company (Cleveland), John Hancock Mutual Life Insurance Company (Hancock), and two employees of Cleveland, Smith, and Borah pursuant to 29 U.S.C. §1132 of the Employee Retirement Income Security Act of 1974 (ERISA). On September 25, 1988, Defendants Cleveland Pneumatic Company, Smith and Borah filed a motion to dismiss the second amended complaint. By order of December 8, 1988, we dismissed Count 1 of the complaint which sought relief for breach of fiduciary duty but denied the motion of these Defendants as to Count 2 which sought relief pursuant to the life insurance plan.

On October 25, 1988, Hancock filed a motion for summary judgment which was granted by order of December 13, 1988. On June 23, 1989, Gridley and Cleveland filed motions based upon newly discovered evidence for reconsideration of the grant of summary judgment in favor of Hancock. By order of August 17, 1989, we vacated the grant of summary judgment in favor of Hancock.

A non-jury trial in this case began on December 19, 1989, and was concluded on January 10, 1990. The following are the Court's findings of fact, discussion, and conclusions of law.

II. Findings of Fact.

1. Plaintiff Gladys M. Gridley is the widow of Joseph R. Gridley, also known as Joe R. Gridley. (Undisputed), hereafter (U).

2. Joseph R. Gridley (decedent) was born December 20, 1930. (U)

3. Decedent died June 19, 1986, at Soldiers and Sailors Memorial Hospital, Wellsboro, Tioga County, Pennsylvania. (U)

4. Joseph R. Gridley's death was caused by pancreatic carcinoma.(U)

5. At all times material, Cleveland Pneumatic Company was a subsidiary of Pneumo Corporation which in turn was a subsidiary of IC Industries with offices and machine shops located in Cleveland, Ohio.

6. At all times material, Defendant Patricia Borah was employed as Employee Benefits Administrator by Cleveland Pneumatic (Cleveland). (U)

7. At all times material, Defendant Marjorie Ann Smith was employed as Manager of employee benefits and services by Cleveland. (U)

8. At all times material, Defendant John Hancock Mutual Life Insurance Company (Hancock) was an insurance company. (U)

9. At some time prior to August 1, 1974, Cleveland Pneumatic had established an Employee's Group Insurance Plan. (U)

10. At all times material, Loretta Parker was an employee of Pneumo Corporation with the title of Director of Employee Benefits Administration and with responsibility for many of the duties imposed on Pneumo Corp. in its role as administrator of insurance for the benefit of its employees known as the Cleveland Pneumatic Group Insurance Plan.

11. The only asset of the plan which was in existence prior to August 1, 1974, consisted of an insurance policy issued by an insurance company called State Mutual.

12. On August 1, 1974, Pneumo Corporation contracted with Hancock for insurance coverage to be provided by Hancock and to "duplicate all coverages previously insured by State Mutual." (U)

13. The purpose of Pneumo Corporation entering into a contract with Hancock was to fund, among others, the Cleveland Pneumatic Group Insurance Plan. (U)

14. The group insurance policy issued by John Hancock to Pneumo Corporation for the benefit of, *inter alia*, Cleveland Pneumatic Company employees, is an employee welfare benefit plan, falling under the terms of and governed by the provisions of the Employee Retirement Income and Security Act (ERISA), 29 U.S.C. §1001, *et seq*. (U)

15. From at least August 1, 1974, through June, 1986, Pneumo Corporation and Hancock contracted for Hancock to provide various classes of employees of Cleveland with insur-

ance benefits, including medical insurance, prescription insurance, long-term disability insurance and life insurance. (U)

16. The day-to-day administration of the Cleveland Pneumatic Plans occurred at Cleveland Pneumatic under the direction of Defendant Smith. (U)

17. The insurance policy and amendments entered into at various times between Pneumo Corporation and Hancock were drafted by Hancock and were submitted to Pneumo Corporation for comments.

18. The master insurance policy entered into between Pneumo Corporation and Hancock was effective August 1, 1974, and bears policy number 23678-GTC. (U)

19. Hancock has no single, standard group life insurance policy. Each group life policy is prepared to meet the specifications of each insured.

20. The master policy aforesaid provides that it shall be governed by the laws of the jurisdiction of "Issue," and the policy was issued in the state of Massachusetts. (U)

21. The Master Policy contains the following provisions (all of which are undisputed):

General Provisions:

Insurance Records

The records with respect to insurance under this policy shall be maintained by the Policyholder. (Exhibit J.H.1, page 1)

Amendment, Renewal and Termination

This policy may be amended or terminated at any time by written agreement between the Insurer and the Policyholder. (U)

...

No amendment, renewal or termination of this policy shall require the consent of or notice to any employee or beneficiary or other person having a beneficial interest herein.

Only the President, a Vice President, the Secretary or an Assistant Secretary has power on behalf of the Insurer to make or change or terminate this Policy. No agent has authority to change this Policy or to waive any of its provisions. (Exhibit J.H. 1, page 3)

Non-Waiver of Policy Provisions

Failure of the Insurer to insist upon compliance with any provision of this policy at any given time or under any given set of circumstances shall not operate to waive or modify such provision, or in any manner whatsoever to render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances are, or are not, the same. (U)

Policyholder not Insurer's Agent

Neither the Policyholder nor any Participating Employer shall be considered the agent of the Insurer for any purpose under this policy. (Exhibit J.H.1, page 3)

Employee's Certificate

The Insurer will issue to the Policyholder for delivery to each insured employee a certificate setting forth a summary of the essential features of the insurance and stating to whom the benefits are payable. (Exhibit J.H.1, page 6)

Conformity with Applicable Law

Any provision of this policy which, on its effective date, is in conflict with the applicable law of the Jurisdic-

tion of Issue is hereby amended to conform with the minimum requirements of that law. (U)

22. The insurance policy provides at Section II, The Cleveland Pneumatic Company, page 3:

> EFFECTIVE DATE OF INSURANCE. If the employee's insurance does not become effective on the date he becomes eligible because he is not actually at work, his insurance will become effective on the date he actually returns to work. (U)

23. The insurance policy provides, under Section II, The Cleveland Pneumatic Company, page L-1:

> INSURING CLAUSE. Upon receipt of due proof of the death of the employee while insured for this benefit, the company will pay to the beneficiary the amount of life insurance in force on the life of the employee. (U)

24. The insurance policy provides, at Section II, The Cleveland Pneumatic Company, page Sch-1:

• • •

> If on the date the amount of the Employee's insurance is determined in accordance with the foregoing the Employee is not actually at work for his Employer, he shall not be entitled to any increase in insurance or any additional benefits for which he may be eligible until he actually returns to work. (U)

...

> 6. This application and the policy and amendments issued hereto by the Company, together with the individual applications, if any, of the persons insured, shall constitute the entire contract between the applicant and the Company. No agent, broker or representative of the Company, other than the President, Vice Presidents (ex-

clusive of Field Vice Presidents), the Secretary or an Assistant Secretary has authority to change this application or any policy or amendment or to waive any of the provisions thereunder or to make or discharge any contracts or to give notice of acceptance by the Company of this application or of any changes of this application. (Exhibit J.H.1, page 20)

Section II of the insurance policy pertaining to the Cleveland Pneumatic Company contains the following provisions:

Employees who may be insured

The class of employees who may be insured under this policy shall consist only of those persons who are permanent, full time employees except that non-exempt and hourly employees not eligible for a State Disability Plan and who have not stopped working due to a labor dispute are the only employees eligible for Weekly Indemnity Insurance.... (Exhibit J.H 1a. page 2)

25. At some time between 1984 and May of 1985, Hancock prepared a document entitled "Your Group Insurance Plan" which it submitted for the review and approval to the Pneumo Administrator of Employee Benefits, Loretta Parker, who approved the form of the document.

26. At some time between 1984 and May of 1985 Hancock printed and distributed to Pneumo a large quantity of the document "Your Group Insurance Plan."

27. The publication, "Your Group Insurance Plan," Plaintiff 14, aforesaid was the "certificate" referred to on page 6 of the master policy. (U)

28. The publication, "Your Group Insurance Plan," Plaintiff 14, referred to hereinabove, was provided by Hancock with

the expectation that it be distributed to Cleveland's salaried, exempt employees.

29. The publication, "Your Group Insurance Plan," Plaintiff 14, states that:

> The Policy constitutes the contract of insurance between the Policyholder and the John Hancock, and controls all the terms and conditions of your insurance. The description of the insurance is set forth in general terms in this booklet but none of the terms or conditions of the policy are waived by anything set forth herein.
>
> The publication, "Your Group Insurance Plan," provides:
>
> ACTIVELY AT WORK REQUIREMENT
>
> If you are not actively at work on the date an increase in benefits would become effective under the Schedules shown herein, such increase will not become effective until the date you return to active work.

(U)

30. While the group insurance contract issued to Pneumo Corp. by Hancock in 1974 states that an employee must be "actually at work" to participate in an increase in benefits, subsequent amendments to the policy after 1974, including the amendments which provided for the basic and supplemental life insurance benefits which were available to Cleveland Pneumatic Company salaried employees as of June 1985 and the amendment which provided for the basic and supplemental life insurance benefits coming into effect January 1, 1986, conditioned the salaried employees' participation in a benefit increase on the employee being "actively at work." (U)

31. The phrase "actively at work" used in the booklet "Your Group Insurance Plan" was never added to the policy by amendment.

32. The certificate booklet was intended to describe the terms of the policy and not to change the terms of the policy.

33. Although the certificate booklet was reviewed by representatives of John Hancock, Pneumo and Cleveland Pneumatic prior to its publication, none of these individuals discovered the discrepancy between the booklet and the policy.

34. The publication, "Your Group Insurance Plan," Plaintiff 14, referred to hereinabove provides:

> The Group Policy and all individual certificates issued under it are governed by the laws of Massachusetts.

35. The publication, "Your Group Insurance Plan," Plaintiff 14, provides:

> WHEN DOES INSURANCE BECOME EFFECTIVE.
>
> For you—insurance becomes effective on the date you become eligible, provided you are actively at work on said date, otherwise on the first date thereafter on which you are actively at work.
>
> 'Actively at work'—an employee shall be considered 'actively at work' if he reports for work on the date in question at his usual place of employment with his Employer and such usual place of employment is outside of his home, and if when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular, full-time basis. If an employee does not so report, or if his usual place of employment with his Employer is not outside of his home, he shall be considered 'actively at work' if at any time on the date in question, he is neither (i) hospital confined, nor (ii) disabled to a degree that he could not then have reported to

a place of employment outside of his home and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

(U)

36. Decedent was employed by Cleveland on May 17, 1985, as a Manufacturing Engineer at an annual salary of $33,500.00 with his insurance benefits to commence the first day of work, June 5, 1985. (U)

37. At all times material, Plaintiff and decedent maintained a home at 11 Sherwood Street, Wellsboro, Tioga County, Pennsylvania. (U)

38. At the time decedent was employed by Cleveland, Plaintiff and decedent rented an apartment in Cleveland on a standard one-year lease agreement. (U)

39. Prior to his employment, decedent was examined by William Coolidge, M.D., who reported on a physical examination form to Cleveland that decedent had suffered cancer of the right lung in 1981 and metastatic cancer of the brain in 1981 and 1982 with no evidence of recurrence.

40. At the time of his employment, Cleveland provided decedent with a copy of the publication, "Your Group Insurance Plan," Plaintiff 14.

41. At the time of his employment, Cleveland provided decedent with a publication entitled "Employee Benefits Summary." Plaintiff 15.

42. The publication, "Employee Benefits Summary," Plaintiff 15, was prepared by an independent contractor for Cleveland for distribution to its salaried, exempt employees.

43. The publication, "Employee Benefits Summary," Plaintiff 15, provides under the heading "INTRODUCTION" as follows:

> The benefit plans provided for you as a full-time permanent salaried exempt employee of [Cleveland] represent an important supplement to your regular earnings. You should know what these plans are and how they work in order to take full advantage of them.
>
> This brochure highlights the major provisions of each of the plans. There is also a section on Company policy regarding paid time away from work and other benefits.
>
> This summary has been prepared for use as a 'quick' reference source of information about your benefit plans. You may refer to your summary plan descriptions or the official plan documents for more details. Of course, in the event of any conflict between this brochure and the plan documents, provision of the plan documents will apply.
>
> When you have questions about your benefits that are not answered in the material given to you please contact the Employee Relations Department.

(U)

44. The publication, "Employee Benefits Summary," Plaintiff 15, contained information with regard to "medical care benefits, dental care benefits, income protection benefits, survivor security benefits, pension plan and other benefits including vacations, holidays, education reimbursements, funeral leave, military training, jury duty and employee assistance program." (U)

45. Under the heading, "SURVIVOR SECURITY," the "Employee Benefits Summary" provided:

> Those who depend on you for support can count on your income while you are actively at work, but there is a need to plan for their continued financial protection in the

event of your death. This protection is provided through Basic Life Insurance, Voluntary Life Insurance,...

Eligibility

You are automatically eligible to participate in our life insurance plans on your first day of employment with the Company.

Cost

All life insurance programs are provided at no cost to you with the exception of Voluntary Life Insurance.

Basic Life Insurance

While actively employed, your basic life insurance benefit will be one and a half times your annual salary, rounded to the next higher $1,000.

Voluntary Life Insurance

You may choose to be covered (at your own expense) for an additional amount of insurance equal to: one-half of your annual salary rounded to the next higher multiple of a thousand dollars, or twice the amount described above....

(U)

46. At the time of his employment with Cleveland Pneumatic Company, Joe Gridley selected voluntary life insurance in the amount of one-half his annual salary, rounded to the next higher $1,000.00, by completing a "group optional life insurance enrollment card" which stated, directly above his signature:

I certify that I am an active, full-time employee of the above-named employer and work a regularly scheduled work week with such employer. I understand that if I do not meet these requirements I am not eligible for any

insurance. I certify I have read and understood the above provisions.

47. Copies of the John Hancock Group Policy were available to employees of Pneumo Corporation's subsidiaries on request through Pneumo's corporate offices in Boston.

48. In mid-November, 1985, IC Industries, the owners of Pneumo Corporation at that time, announced to Defendant Smith that it was providing for salaried, exempt employees new benefits for, among other things, health insurance, life insurance and prescription insurance to be effective January 1, 1986. (U)

49. Smith attended a meeting at Pneumo corporate headquarters in Boston on November 15, 1985, and received at that meeting a written transcript and slides explaining the benefit changes. (U)

50. Smith was advised at that meeting that the life insurance benefit would be changed so that company paid life insurance would increase to three times annual salary, and supplemental or what had been known as Voluntary Life Insurance would be provided at one, two or three times annual salary to be paid for by the employee. (U)

51. At the November 15, 1985, meeting, Smith was provided with enrollment cards and a package of information concerning the new benefit program which each affected employee would receive.

52. The transcript, slides and written information which Smith received at the November 15, 1985, meeting were prepared by an independent contractor for Cleveland's parent company or companies.

53. There was no discussion at the November 15, 1985, meeting of any requirement that employees be actively at work to qualify for the new benefit program.

54. Plaintiff, as decedent's spouse, was invited by Smith to attend a meeting in Cleveland, Ohio, on November 25, 1985, for the purpose of explaining to salaried, non-exempt employees the benefit changes which were to be effective January 1, 1986. (U)

55. At the meeting of November 25, 1985, Smith did not indicate to those in attendance that there was any requirement that to be eligible for the increased benefits to become effective January 1, 1986, employees had to be "actively at work." (U)

56. At no time prior to the decedent's death, did the Defendant Smith or the Defendant Borah ever orally advise Plaintiff or decedent that decedent would have to be "actively at work" to be eligible for the new benefits to be effective January 1, 1986. (U)

57. At the meeting of November 25, 1985, Smith presented the slide presentation and read the transcript provided as the same is set forth in Plaintiff's Exhibit 18. (U)

58. The slide presentation and transcript informed those at the November 25, 1985, meeting that:

> We are continuing our commitment to you and your family by expanding your company-paid protection. On January 1, 1986, your Basic Life Insurance will be equal to three (3) times your base annual salary....
>
> Because your needs for survivor security may be different, you now have more choices for individual insurance. At attractive group insurance rates, you may purchase life

> insurance for yourself in amounts of one, two, or three times your base annual salary....

(U)

59. There is no reference in the slides or in the transcript accompanying the slides of any requirement that employees must be "actively at work" to be eligible for the new benefits to be effective January 1, 1986. (U)

60. At the November 25, 1985, meeting, Plaintiff was provided with a pamphlet entitled, "Employee Benefits Summary," Plaintiff 19.

61. The "Employee Benefit [sic] Summary," distributed at the November 25, 1985 meeting, summarized the material modifications in employee benefits coming into effect on January 1, 1986. (U)

62. The publication, "Employee Benefits Summary," Plaintiff 19 was prepared for Cleveland by an independent contractor for distribution to its salaried, exempt employees. (U)

63. The "Employee Benefits Summary," Plaintiff 19, was not reviewed by John Hancock or approved by John Hancock and John Hancock had no hand in its preparation.

64. The publication delivered November 25, 1985, entitled "Employee Benefits Summary," Plaintiff 19, provides under the heading "INTRODUCTION" the following:

> The benefit plans provided for you as a full-time permanent salaried employee of Pneumo Corporation represent an important supplement to your regular earnings. You should know what these plans are and how they work in order to take full advantage of them.
>
> This brochure highlights the major provisions of each of the plans as they will be in effect on January 1, 1986.

> This summary has been prepared for use as a 'quick' reference source of information about your benefit plans. You may refer to your summary plan descriptions or the official plan documents for more details. Of course, in the event of any conflict between this brochure and the plan documents, provisions of the plan documents will apply.
>
> When you have questions about your benefits that are not answered in the material given to you, please contact the Employee Relations Department.

(U)

65. Under the heading "SURVIVOR SECURITY," the same brochure provided:

> Those who depend on you for support can count on your income while you are actively at work, but there is a need to plan for their continued financial protection in the event of your death. This protection is provided through basic life insurance, supplemental life insurance, ...
>
> *Eligibility*
>
> You are automatically eligible to participate in our life insurance plans on your first day of employment with the Company.
>
> *Cost*
>
> All basic life insurance programs are provided at no cost to you. The Supplemental programs—...—require your contributions.
>
> *Basic Life Insurance*
>
> While actively employed, your basic life insurance benefit will be 3 times your base annual salary, rounded to the next higher $1,000....

Supplemental Life Insurance

You may choose to be covered (at your own expense) for an additional amount of insurance equal to one, two, or three times your base annual salary, rounded to the next higher $1,000....

(U)

66. At the meeting of November 25, 1985, Plaintiff presented to the Defendant Smith a note, Plaintiff 22, from Dr. Marvin L. Perry, dated November 23, 1985, which stated, "Mr. Joe Gridley is being treated for malignancy. He is unable to work." (U)

67. At the meeting of November 25, 1985, Plaintiff was provided with an enrollment form for group optional insurance and a beneficiary designation form, Plaintiff 24. (U)

68. On November 25, 1985, Defendant Smith knew there were three salaried, exempt employees of Cleveland off work.

69. At the meeting of November 25, 1985, Defendant Smith advised those in attendance, including Plaintiff, that the enrollment card should be signed and returned promptly to Cleveland so that timely arrangements could be made for payroll deductions for premiums and company payment of premiums in advance of the effective date of the change, January 1, 1986. The off-work employees and their spousal representative or representatives were directed to sign and return the enrollment cards by Smith despite Smith's knowledge that the card required the signing employee to certify that he was "an active full-time employee of the above-named employer and work a regularly scheduled work week with such employer."

70. Defendant Smith did not inform any of the three employees who were off work as of November 25, 1985, or

their spouses that the off-work employees should delay signing and returning to Cleveland the enrollment cards for the new life insurance program effective January 1, 1986, Plaintiff's Exhibit No. 24.

71. The procedure established by the Defendant Smith and Cleveland with respect to the enrollment cards was that they were to be forwarded upon receipt at Cleveland's office to the Payroll Department so that arrangements could be made for the company-paid premium as well as the payroll deduction for the amount of insurance selected by each employee on the enrollment card. (U)

72. Defendant Smith knew of the actively-at-work requirement, knew that there were three employees off work as of November 25, 1985, yet informed those employees or their spouses to sign and return the enrollment cards promptly so that they, along with the cards for the at-work employees, would be processed for payroll deduction prior to January 1, 1986.

73. On November 26, 1985, decedent read and signed the group optional insurance enrollment form selecting supplemental life insurance at three times his salary. The enrollment form requested Cleveland to arrange for the issuance of group insurance and authorized deductions from earnings for required contributions. The form contained the following language immediately above decedent's signature:

> I certify that I am an active, full-time employee of the above-named employer and work a regularly scheduled work week with such employer. I understand that if I do not meet these requirements, I am not eligible for any insurance. I certify I have read and understood the above provisions.

74. It was Joseph Gridley's custom to read documents, such as the enrollment form, before signing.

75. The group optional life insurance enrollment card which Gridley signed at the time of his first employment and the group optional insurance enrollment form which Gridley signed on November 26, 1985 were forms prepared by John Hancock, for distribution to Cleveland Pneumatic Company salaried employees, among others. (U)

76. The said enrollment form was routinely processed with over 1,000 other cards from Cleveland Pneumatic Company's salaried employees.

77. By letter dated November 26, 1985, Plaintiff 23, Plaintiff forwarded to Defendant Smith the enrollment form and a group health plan statement of claim, Plaintiff 23, signed by decedent November 26, 1985. (U)

78. Gladys Gridley and Joseph Gridley retained a copy of the group optional insurance enrollment form, signed by decedent on November 26, 1985.

79. Hancock did not issue to Pneumo for delivery to each insured employee a certificate setting forth a summary of the essential features of the insurance and stating to whom the benefits are payable with reference to the amendments effective January 1, 1986.

80. In February 1986, Gladys Gridley and decedent read and discussed the enrollment form.

81. Gladys M. Gridley could not recall ever discussing the booklet, "Your Group Insurance Plan," with her husband.

82. Neither Plaintiff nor her decedent ever discussed the "actively at work" provision of the life insurance policy with anyone at Cleveland or Hancock.

83. On or about November 26, 1985, a health claim form was signed by Dr. Perry, Plaintiff 25, and thereafter submitted to Cleveland for payment of services rendered by Dr. Perry to decedent from November 16, 1985, through November 23, 1985, said form indicating a diagnosis of "carcinoma of pancreas with metastasis." (U)

84. The said health claim form, Plaintiff 25, Posed the question, at block number 17 "date patient able to return to work" and contained the answer, certified by Dr. Perry, "indefinite".

85. In order to qualify for benefits under the salary continuance plan, decedent submitted to Cleveland Pneumatic Company the note from Dr. Marvin L. Perry dated November 23, 1985, stating "Mr. Joe Gridley is being treated for Malignancy. He is unable to work."

86. In early December, 1985, Plaintiff and decedent vacated their apartment in Cleveland and returned to their home in Wellsboro which had been vacant. (U)

87. At the time the Plaintiff and her decedent left their apartment in Cleveland, they surrendered their one-year lease and lost the one-month security deposit which had been paid. (U)

88. At the time the Plaintiff and her decedent left Cleveland, Plaintiff and decedent secured a cancellation of their lease agreement. (U)

89. At the time the Plaintiff and her decedent left Cleveland, they did not intend to return to Cleveland to reside unless Mr. Gridley recovered sufficiently to return to work.

90. Decedent and Plaintiff returned to Wellsboro so that Mr. Gridley could secure medical treatment from the physi-

cian who had treated him for earlier cancer, Dr. F. Ardell Thomas.

91. Decedent was hospitalized at Soldiers and Sailors Memorial Hospital in Wellsboro, Tioga County, Pennsylvania, from December 9, 1985, through December 22, 1985, during which hospitalization a biopsy of the head of the pancreas was performed with Roux-en-Y cholecystojejunostomy and gastroenerostomy performed by Dr. Robert C. Bair. (U)

92. Decedent's job at Cleveland required his presence at the Cleveland Pneumatic Company plant in Cleveland.

93. Decedent was seen by Dr. Thomas in his office in Wellsboro on December 2, 1985; January 15, 1986; March 5, 1986; April 21, 1986; April 30, 1986; and May 4, 1986. (U)

94. Matters concerning payroll deduction for payment of premiums for supplemental life insurance were handled by the payroll department of Cleveland. (U)

95. In January and February, 1986, after the benefit program changed, Marjorie Smith received many telephone calls per working day from employees and their spouses, concerning questions about benefits.

96. After decedent left work on November 15, 1985, he was paid under Cleveland's salary continuance plan as described in Plaintiff's Exhibits 20 and 30. (U)

97. The salary continuance plan is described in a publication entitled, "Summary Plan Description Salary Continuance Plan for Salaried, Exempt Employees," prepared by an independent contractor for Cleveland and presented to decedent at the time of his initial employment in June of 1985.

98. The salary continuance plan basically provided for continuance of payment of salary for a period not to exceed 25

weeks in the event of illness or disability which extended past seven consecutive calendar days. (U)

99. On February 6, 1986, Defendant Borah sent to Joseph Gridley a memo indicating a subject of "Cleveland Pneumatic Salary Continuance" and stating the following:

> To continue your eligibility in the company's Salary Continuance Program the enclosed form must be completed by you and your physician as soon as possible.
>
> Upon completion, the form must be returned to the Employee Benefits Department in the self-addressed mailing envelope provided for your convenience.
>
> Failure to return this form promptly will jeopardize your eligibility for salary continuance.
>
> The said form stated at the bottom of the form:
>
> *Reminder:* When your doctor has discharged you, you must be examined by the company physician before you may return to work. Contact the company dispensary, 341-1700, ext. 4600, for an appointment.

100. The form referred to in the memo of February 6, 1986 was a supplementary medical report form which decedent gave to his treating physician, Dr. Thomas, for completion.

101. In the Supplementary Medical Report of February 10, 1986, Dr. Thomas indicated that the decedent was still under his care. (U)

102. On February 21, 1986, Cleveland issued standard operating procedures for the salary continuance plan which provided:

Eligible Employee

Any Salary, Exempt or Non-Exempt Full-Time Employee who is unable to work due to illness or disability for a period which extends past seven consecutive calendar days. Benefits commence from the eighth consecutive calendar day of illness or disability. Benefits will continue for the period employee is unable to work but in no event for any period longer than 25 consecutive weeks after the one week waiting period.

(U)

103. The salary continuance plan provides as follows:

Salary Exempt Employees

The amount of benefit for the waiting week and the following 16 weeks of covered absence will equal 100% of base salary; the remaining weeks of covered absence up to a maximum of 9 weeks will equal 80% of base salary ....

(U)

104. Decedent's regular work week at Cleveland was eight hours a day, five days per week, with occasional non-mandatory Saturday overtime. (U)

105. As a manufacturing engineer, decedent had a desk on the second floor over a machine shop which was located on the first floor and spent an average of 30 percent of his work day at his desk and an average of 70 percent in the machine shop, with the actual percentage varying from day to day. (U)

106. Decedent was not required to perform any lifting, bending, stooping, nor was he required to perform any hands-on repair or alteration of any machines. (U)

107. In an application for long term disability benefits, filled out by Joseph Gridley on May 6, 1986, decedent indicated that his job involved carrying IBM printouts and tooling weighing from 10 to 40 pounds, and carrying 10 pound weights frequently, for distances of up to 20 feet, and 40 pounds occasionally, for distances of up to two feet. Decedent indicated that during a typical work day, he spent one hour walking, two hours standing, and five hours sitting. (U)

108. While in the machine shop, Mr. Gridley was in a variety of positions, including a combination of standing, sitting and walking. (U)

109. While in the machine shop, Mr. Gridley's job was to examine the blueprint for the part being machined to find out what may be causing a problem with the part not being within the blueprint tolerances and to advise as to how the problem could be corrected.

110. There was no elevator from the second floor to the first floor so that Mr. Gridley was required to climb a flight of steps to move from his office to the machine shop and back to the office. (U)

111. The shop at Cleveland Pneumatic Company is approximately 200 yards in length, and approximately 100 yards in width.

112. From January 1 through the date of his death on June 19, 1986, decedent took several extended automobile trips with the Plaintiff during which the driving was shared between decedent and Plaintiff.

113. From January 1, 1986, until approximately one week before his death, decedent and Plaintiff took regular walks and short rides in their automobile, again sharing the driving between the decedent and the Plaintiff.

114. During a period of time from approximately mid January of 1986, until approximately early March of 1986, decedent was physically capable of being present at his place of employment performing all the usual and customary duties of his job on a regular, full-time basis.

115. Subsequent to November 15, 1985, through the time of Joe Gridley's death, the only information Defendants received concerning Joe Gridley's state of health indicated that he was incapable of performing his job by reason of his illness.

116. On February 10, 1986, Dr. F. Ardell Thomas submitted to Cleveland an "Attending Physician's Supplementary Statement" as a part of a "Supplementary Medical Report" providing his "diagnosis and current conditions" of "carcinoma of head of pancreas with metastasis in the right of adrenal gland, previous carcinoma of lung, previous carcinoma metastatic to brain," Plaintiff 29. (U)

117. In the Supplementary Medical Report of February 10, 1986, Dr. Thomas indicated that decedent was "continuously totally disabled (unable to work) from 11/16/85 through indefinite" and as to "if still disabled, date patient should be able to return to work," Dr. Thomas's response was "indefinite." (U)

118. In order to qualify for benefits under the Cleveland Pneumatic Salary Continuance Plan, an employee must establish illness or disability which causes an inability to work. (U)

119. On April 17, 1986, Defendant Borah sent to Joseph Gridley a memo indicating a subject of "CPC Salary Continuance" and stating the following:

> To continue your eligibility in the company's Salary Continuance Program the enclosed form must be completed by you and your physician as soon as possible.

> Upon completion, the form must be returned to the Employee Benefits Department in the self-addressed mailing envelope provided for your convenience.
>
> Failure to return this form promptly will jeopardize your eligibility for salary continuance.
>
> The said form stated at the bottom of the form:
>
> *Reminder:* When your doctor has discharged you, you must be examined by the company physician before you may return to work. Contact the company dispensary, 341-1700, ext. 4600, for an appointment.

120. The form referred to in the memo of April 17, 1986, was a supplementary medical report form, which decedent gave to his treating physician, Dr. Thomas, for completion.

121. On April 21, 1986, Dr. F. Ardell Thomas submitted to Cleveland an "Attending Physician's Supplementary Statement", Plaintiff 38, as a part of a "Supplementary Medical Report" providing his "diagnosis and current conditions (include restrictions that prevent return to work)" of "carcinoma of head of pancreas with metastasis to the right of adrenal gland, previous carcinoma of lung, previous carcinoma metastatic to brain." Dr. Thomas further indicated that decedent was "continuously totally disabled (unable to work) from November 16, 1985 through indefinite" and as to "if still disabled, date patient should be able to return to work," his response was "indefinite."

122. Dr. Thomas knew that the form completed on April 21, 1986, and the form he had earlier completed on February 10, 1986, were for the purpose of securing decedent's receipt of benefits based on disability.

123. Cleveland Pneumatic Company required employees to obtain medical clearance from the company medical direc-

tor after the employee had been absent for more than a week even if the employee's treating physician had certified the employee as able to work.

124. Dr. Thomas testified that he no longer believes his statements with respect to disability on the supplementary medical report dated February 2, 1986, were accurate inasmuch as decedent could have returned to his work for the period of time indicated hereinabove had decedent realized that to do so would have meant the receipt by his widow of substantially increased insurance benefits.

125. Dr. Thomas was never told by Gridley that he intended to return to Cleveland to reside. (U)

126. Decedent received prescription benefits under the new plan effective January 1, 1986. (U)

127. Cleveland maintained in its office in Cleveland a form entitled "Record of Medical Treatment to Employee." The following entries appear in that report with respect to the decedent:

> 11/27/85, 2:51 p.m., received note dated 11/23/85 and signed by Marvin L. Perry, M.D., "being treated for malignancy. He is unable to work."
>
> 1/13/86, statement of claim rec. this date. LDW 11/14/85 RTW N/O Ca. of Pancreas with
>
> 3/24/86 Supplementary medical report Rec. this date. Diag: carcinoma of head of pancreas with metastasis to rit. Adrenal gland per F. Ardell Thomas, M.D. RTW N/A
>
> 5/5/86 Supplementary medical report rec. this date. Diag: Ca. Head of pancreas per F. Ardell Thomas, M.D. RTW N/A

(U)

128. For each of the months of January and February, 1985, $25.13 per month was deducted from decedent's pay for supplemental insurance, Plaintiff 37, and was remitted by Cleveland to Hancock.

129. The amount deducted for January and February was based upon a premium cost of 25 cents per thousand. (U)

130. Under the new benefit plan effective January 1, 1986, the correct deduction for decedent for supplemental insurance in the amount of three times his salary would be $60.60 per month, if he were eligible for such benefits. (U)

131. On February 27, 1986, Plaintiff telephoned Defendant Smith for the purpose of informing Defendant Smith that Plaintiff felt the amount being deducted for supplemental insurance, i.e., $25.13, was not correct and that $60.60 should be deducted. (U)

132. Ceil Bolster, an employee in the Payroll Department of Cleveland Pneumatic Company, informed Plaintiff that, if her husband had $101,000.00 in supplemental insurance benefits, the appropriate deduction would be $60.60.

133. Ceil Bolster was unaware of Plaintiff's eligibility or ineligibility for the increased supplemental life insurance benefit under the new plan effective January 1, 1986.

134. Ceil Bolster agreed to institute a deduction of $60.60 from Plaintiff's monthly pay.

135. $60.60 per month was deducted from decedent's paychecks for the months of March, April and May, 1986, by Cleveland and remitted to Hancock. (U)

136. The following deductions were made from decedent's wages or sick pay for insurance: a) August 18, 1985—$15.47; b) September 15, 1985—$15.47; c) October 13, 1985—$15.47; d) November 24, 1985—$15.47; e) December

22, 1985—$15.47; f) January 19, 1986—$25.13; g) February 16, 1986—$25.13; h) March 6, 1986—$60.60; i) April 13, 1986—$60.60; and j) May 11, 1986—$60.60. (U)

137. On May 6, 1986, decedent submitted an application for long-term, disability benefits under a plan established by Pneumo Corporation and funded by a trust at New England Merchants National Bank, Plaintiff 39 and Plaintiff 40. (U)

138. Following the conclusion of his 25 weeks of eligibility, on the basis of disability, under Cleveland's salary continuance plan, Joseph Gridley became eligible for long term disability benefits under the Pneumo Corp. Long Term Disability Plan, on the basis of further disability.

139. In his application for long term disability benefits, decedent indicated that he was suffering from "extreme fatigue and shortness of breath upon any slight exertion, very weak, bouts of nausea, discomfort and abdominal and right back kidney region pain, phlebitis in legs with difficulty sleeping nights, difficulty concentrating, difficulty eating and continual weight loss," Plaintiff's Exhibit 39. (U)

140. In the attending physician's statement completed by Dr. Thomas in connection with decedent's application for group life insurance disability benefits, Dr. Thomas indicated, under the category of "physical impairment," that Plaintiff was "class four—marked limitation. (60-70 percent)", in preference to lower categories, including "class three—moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (35-55 percent)". (U)

141. The said application for long term disability benefits asked "Has your doctor told you to restrict your activities any way?", to which question decedent replied "Yes." The form then asked "If 'yes' give name of doctor and state what he told

you about restricting your activities", to which the decedent replied "Dr. Thomas—no lifting, no driving car, not to go upstairs ..."

142. In the said application, decedent indicated that he was able to go outside only with the help of another person or device. (U)

143. In that same application, decedent indicated that it was indefinite as to his return to work and that he was depending on others for daily needs of living, unable to do household maintenance, cannot drive car—dependent on others for transportation to doctors. Part B of the same application was completed by Dr. Thomas, who indicated decedent's progress was "retrogressed," that the prognosis was one of deterioration, that decedent was suffering from cancer inoperable and would progress and that decedent was not a candidate for trial employment or job training. (U)

144. Upon receipt of decedent's application for long-term disability benefits, Defendant Borah prepared and submitted to Pneumo Corporation a disability claim form indicating that Plaintiff had been disabled from November 16, 1985 because of illness. (See Plaintiff's Exhibit 41) (U)

145. On or about February 17, 1986, Joseph Gridley was awarded Social Security Disability benefits. (Exhibit JH4) (U)

146. The award of Social Security benefits to Joseph Gridley was based upon certifications prepared by his treating physician that he was disabled.

147. The Social Security Administration determined that Joseph Gridley was disabled beginning November 15, 1985. (U)

148. Upon receipt of Plaintiff's Exhibits 39 and 40, Defendant Borah prepared and submitted to Hancock a disability

claim indicating in connection with life insurance that with regard to amount of insurance, basic—$101,000, supplemental, $101,000, for a total of $202,000. She indicated that Plaintiff had been disabled from November 16, 1985, because of illness, Plaintiff 41. (U)

149. Plaintiff spoke with Defendant Borah on June 11, 1986, making inquiries concerning premiums for decedent and herself on both basic and supplemental life insurance and indicated that they both wished premiums on the health insurance and supplemental voluntary life insurance to continue. Plaintiff followed this telephone conversation with a letter dated June 12, 1986, Plaintiff 44. (U)

150. Plaintiff called Defendant Smith on June 17, 1986, and was advised to send a check for the supplemental life insurance premium in the amount of $60.60 and a check for additional health coverage in the amount of $10.00 for the month of July inasmuch as Defendant Smith told Plaintiff that Cleveland paid for the first 30-day "grace period" for the month of June. Defendant Smith advised Plaintiff that the health coverage and basic life and supplemental life would be continued but that dental coverage would end June, 1986. Plaintiff followed this telephone conversation with a letter dated June 17, 1986, enclosing checks to Cleveland for $60.60 and $10.00.

151. None of the Defendants ever orally told the Plaintiff or decedent that Plaintiff would receive $202,000.00 in life insurance benefits in the event of decedent's death.

152. Neither Gladys Gridley nor her husband ever advised Cleveland Pneumatic that her husband's condition was terminal and that he would not be returning to work.

153. Decedent entered Soldiers & Sailors Memorial Hospital, Wellsboro, Tioga County, Pennsylvania, June 16, 1986, and died there June 19, 1986. (U)

154. By letter dated June 23, 1986, Plaintiff advised Defendant Smith of decedent's death and requested forms to process the application for life insurance benefits, Plaintiff 49. (U)

155. Defendant Smith was the person at Cleveland with the authority preliminarily to determine eligibility for life insurance coverage under the new program effective January 1, 1986.

156. Defendants Smith and Borah and Cleveland submitted to Hancock, following decedent's death, a death claim pertaining to Joseph Gridley indicating under "amount of insurance" basic $101,000, opt., add. or supp. $101,000, "total $202,000" and that date last worked was 11/15/85; further, that the original effective date of [decedent's] insurance was June 3, 1985. The Defendants Smith, Borah and Cleveland answered the question, "Was insured considered a member/employee at date of death?" "Yes."

157. At the time Defendant Borah submitted the form indicating these life insurance benefits she was uncertain as to whether Plaintiff would qualify for benefits under the new plan effective January 1, 1986.

158. Defendant Borah consulted with Loretta Parker concerning what dollar amounts to show for life insurance benefits on the form and was advised by Parker to submit the form with the higher amount, $202,000.00, on it, so as to obtain from Hancock a determination of Gridley's eligibility for the higher insurance benefit.

159. Loretta Parker received a memo from Marjorie Smith dated September 8, 1986, indicating its subject as "synopsis of Joseph Gridley's situation." This memo informed Ms. Parker of Mrs. Gridley having been invited to attend the meeting concerning the new benefits, in November, 1985. The memo informed Ms. Parker that Mrs. Gridley had taken an enrollment card for her husband to sign and return, which was mailed in and entered into the system with 1,100 other cards. The memo further informed Ms. Parker of the deductions which had been made from Gridley's salary continuance payment for supplemental life insurance. The memo informed Ms. Parker that Gridley had never returned to work. (U)

160. The memo informed Ms. Parker "Mrs. Gridley called to report when he [Joe Gridley] wasn't returning and also told us he was doing better." (U)

161. Upon receipt of the death claim application pertaining to the life insurance claim of Plaintiff the claims approver employed by Hancock determined that Joseph Gridley appeared to be ineligible for the life insurance benefit increase which became effective January 1, 1986, in that he had not been actively at work at any time subsequent to January 1, 1986. (U)

162. From November 15, 1985, through the date of his death, decedent never again was physically present at his place of work at Cleveland Pneumatic Company and never again performed any work for Cleveland Pneumatic Company. (U)

163. The claims approver reported this conclusion to Jack Cline who indicated that he would discuss the matter with representatives of Pneumo Corp. (U)

164. Jack Cline was at that time employed by Hancock as an underwriting account executive and in that role was Pneumo Corporation's primary contact at Hancock. (U)

165. Jack Cline contacted Loretta Parker of Pneumo Corp., reported the findings of the claims approver, and inquired as to whether Pneumo Corp. would request a waiver of the "actively at work condition." (U)

166. Waivers of Policy Conditions are granted on occasion on health benefit claims by Hancock because of mitigating circumstances or unusual circumstances that would not have been contemplated under the terms of the insurance contract.

167. Prior to the Gridley claim, Hancock had on occasion granted Waivers of Policy Conditions in connection with health insurance claims of employees of Pneumo Corp. or its subsidiaries.

168. On occasion, at the request of the policyholder, Hancock has waived the "actively at work" requirement for eligibility for new benefits at least as to health insurance benefits.

169. Hancock has never granted a waiver of Policy Conditions to Pneumo Corporation or its subsidiaries in an employee's life insurance claim.

170. Decisions with respect to policy-holder requested waivers on a claim of this size are policy-level decisions made by high-level Hancock executives. (U)

171. Hancock has no written policy, regulations or criteria for handling requests for waiver of conditions precedent by policyholders.

172. Loretta Parker consulted with Marjorie Smith concerning the background of the Gridley claim.

173. Loretta Parker decided, on behalf of Pneumo Corporation, the plan administrator, that the request of a waiver would be inappropriate. (U)

174. Pneumo recommended that decedent's claim for life insurance benefits should be paid under the old plan in the total amount of $68,000.

175. Since no waiver was requested, it is unknown whether a waiver would have been granted by John Hancock. (U)

176. Prior to decedent's death, Defendants Smith and Borah realized that there was a question as to whether or not decedent was entitled to benefits under the new benefit package effective January 1, 1986, because of the "actively at work" condition. (U)

177. Neither Defendant Smith nor Borah nor anyone at Cleveland orally advised either decedent or Plaintiff that there was any question as to his entitlement to benefits under the new benefit plan effective January 1, 1986, because of the "actively at work" requirement prior to decedent's death. (U)

178. Decedent would have been clearly eligible for benefits under the new plan effective January 1, 1986, had he returned to work at any time after January 1, 1986, capable of performing all the usual and customary duties of his occupation on a regular, full-time basis.

179. On July 17, 1986, Borah submitted to Hancock the death claim proofs which included form 10-G, Plaintiff 84, and the certificate of death. (U)

180. Form 10G constituted the first notice to Hancock that Gridley was, in fact, insured under the group policy, had applied for the increased amount of life insurance, and that the last day he worked was November 15, 1985.

181. After decedent's death, it was determined that it was not necessary for Plaintiff to pay the $60.60 premium for supplemental life insurance for July, and that check dated July 17, 1986, in the amount of $60.60 was returned to her by Cleveland. (U)

182. In August of 1986, Hancock employees, processing the claim for decedent's life insurance benefits, concluded that decedent was not "actively at work" after January 1, 1986, and, therefore, should receive payment under the plan effective prior to January 1, 1986.

183. By note dated September 8, 1986, Defendant Smith informed Loretta R. Parker, Benefits Administrator for the corporation, of the background concerning the Gridley claim and stated to her in conclusion, "Your determination in this case is important."

184. Decedent's medical expenses were processed and paid under the old medical plan in effect prior to January 1, 1986.

185. By letter dated September 25, 1986, James E. Carlson, Esquire, wrote Defendant Borah inquiring as to the reason for delay in receipt by Plaintiff of benefits from Hancock. (U)

186. Loretta Parker was supervised by the Vice President and Treasurer of Pneumo Corporation, Dan Mahoney. (U)

187. Loretta Parker, of Pneumo Corporation, discussed the issue of whether Plaintiff's decedent was "actively at work" with Jack Cline of John Hancock and both agreed that Gridley was not "actively at work" under the terms of the plan and the Policy.

188. The actual contract document or insurance policy and amendments entered into at various times between Pneumo Corp. and Hancock were drafted by Hancock.

189. There is no definition of "actively at work" in the master policy itself or in the amendment of November 7, 1986 which became effective January 1, 1986, with respect to the new benefits package.

190. The master insurance policy entered into between Pneumo Corporation and Hancock contains no "actively at work" requirement for eligibility.

191. The employees at Hancock were surprised that there was no definition of "actively at work" in the master policy.

192. The summary plan description for the salary continuance plan provided:

> Eligibility—If you are covered by the Plan and are unable to work due to illness or disability for a period which extends past seven consecutive, calendar days, you will be eligible to receive benefits under this Plan during the period you are absent from work beginning with the eighth consecutive, calendar day of your illness or disability ...
>
> The benefits provided under this Plan will continue for the period you are unable to work, but in no event for any period longer than 25 consecutive weeks.
>
> Any illness or disability which causes your absence from work must be certified by a physician satisfactory to the Company, and confirmation of continuing disability or illness may be required from time to time. The Company may require that you be examined by a physician selected by it. (Page 6 of Plaintiff's Exhibit 20) (U)

193. Subsequent to his death, Hancock's long term disability claim office in Lynnfield, Massachusetts, on July 17, 1986, approved decedent's long term disability benefit application and issued a check, payable from Pneumo Corp.'s long term disability trust, for disability benefits for the period from the cessation of decedent's salary continuance benefits through the date of his death.

194. Based upon the submission of Form 12GH-A entitled "Supplementary Medical Report" containing the certifications of Dr. Thomas and dated February 10, 1986 and April 21, 1986, Cleveland Pneumatic paid to Joseph Gridley salary continuance benefits.

195. Cleveland Pneumatic relied upon the representations of Gridley and Dr. F. Ardell Thomas found in the reports in paying salary continuance benefits to Joseph Gridley.

196. Cleveland Pneumatic relied upon Joseph Gridley's application for long-term disability benefits and on his applications for salary continuance in determining that Gridley was qualified to receive long-term disability benefits under the Pneumo plan.

197. Plaintiff received a check in the amount of $1,028.50 from Pneumo Corporation's long-term disability plan for disability benefits for a period of one month, three days, through June 19, 1986. (U)

198. Under the Pneumo Corporation long-term disability plan, an employee is eligible for benefits after the employee has been disabled for a period of 26 weeks and after said disability is certified by a physician satisfactory to Pneumo Corporation. (Exhibit JH7, page 6-7). (U)

199. On October 2, 1986, Hancock, by Senior Approver, Joanne Zorbas, wrote the following letter to Defendant Borah:

This is in regard to the Group Death claim submitted on the above for $202,000.00 (Basic $101,000.00 and Supplemental $101,000.00) under the Plan Change of your Group Policy of January 1, 1986.

According to the claim proofs submitted, Mr. Gridley ceased work, due to illness, on November 15, 1985 and never returned to work prior to his death on June 19, 1986. Although he signed up for the January 1, 1986 Plan Change on November 26, 1985, he did not become eligible for this increase in benefits as he was not actively at work on the date of the Plan Change, January 1, 1986, or any time thereafter.

With regards to this actively at work requirement, the Group Policies state in part as follows:

... Actively at Work

If any employee is not actively at work on the ... effective date, any change in benefits provided by ... Schedule shall not apply to such employee until the date he returns to active work....

Because Mr. Gridley is ineligible for insurance benefits under the January 1, 1986 Plan Change, he was insured at death for $51,000.00 under the Basic Life Insurance Schedule which is one and one-half times the annual salary rounded to the next higher $1,000.00 and $17,000.00 Optional under the first Optional Plan A which is equal to 50% of his annual salary rounded to the next higher $1,000.00, which he elected on June 4, 1985 and which was the Plan in effect at the time of his cessation of active work and thus, was the Plan in effect at death. Enclosed is our check for $68,426.26, which includes interest found due, less 20% Federal Tax with-

holding, in full settlement of the proceeds due under your policy for delivery to the beneficiary.

Based on the Policy terms, this Company must deny any additional liability over the amount of its admitted liability of $68,000.00, plus interest which is tendered with this letter.

We also enclose the Company's check, payable to your Company's order for $232.06, which represents a refund of all premiums paid on the additional amount of insurance requested under the new Plan of January 1, 1986. We understand that $106.41 of this amount represents the employee's contribution. Please refund that amount to the employee's Estate.

We wish our reply concerning insurance benefit under the new Plan could have been favorable but, under the circumstances, this was not possible.

Please notify the beneficiary of the Company's Decision. (Plaintiff 79A, check 79B, 79C)

(U)

200. By letter dated October 9, 1986, Defendant Borah sent Plaintiff Zorbas's letter of October 2, 1986, and a check from Hancock in the amount of $68,426.26 representing the life insurance benefit in the amount of $68,000.00, and interest in the amount of $532.82, with federal tax being withheld from interest in the amount of $106.56, Plaintiff 79B.

201. On or about October 21, 1986, Gladys M. Gridley endorsed the check from John Hancock Life Insurance Company and deposited the same in her bank account. (U)

202. No limitations were placed upon the endorsement by Gladys M. Gridley.

203. By letter dated October 16, 1986, Thomas A. Walrath, Esquire, wrote Defendant Borah and requested a definition of the term "actively at work". Borah did not respond to this letter nor did Cleveland, Plaintiff 8. (U)

204. By letter dated November 22, 1986, Defendant Borah remitted to Plaintiff a check in the amount of $106.41 representing payments made by decedent, "for the additional contributory life insurance premiums, collected in error," Plaintiff 81 check and letter. (U)

205. The amendment which established the new benefits effective January 1, 1986, provides the following:

> If any employee is not actively at work on the above effective date, any change in benefits provided by the following Schedule shall not apply to such employee until the date he returns to active work.

(U)

206. The amendment to the master policy, effective January 1, 1986, is dated November 7, 1986, and was executed by Pneumo Corporation and Hancock after decedent's death, Plaintiff 82. (U)

207. In or about February of 1986, decedent and Plaintiff had a discussion concerning whether or not decedent was, in fact, being provided with life insurance coverage and benefits under the new plan effective January 1, 1986.

208. At all times subsequent to January 1, 1986, and up until the date of his death in June of 1986, decedent believed that he was entitled to life insurance benefits under the new life insurance program which became effective January 1, 1986.

209. At all times subsequent to January 1, 1986, and up until the date she received Plaintiff's Exhibit No. 79a, Plaintiff

believed she would receive life insurance benefits in the amount of $202,000 as a result of her husband's death and his entitlement to such benefits under the Cleveland/Hancock plan.

210. Decedent was an employee of Cleveland from the date of his initial employment until his death. (U)

211. Cleveland Pneumatic did not have a copy of the John Hancock group life insurance policy at its Cleveland office. (U)

212. Defendant Smith does not know whether an employee requesting a copy of the John Hancock group life insurance policy would obtain one or not.

213. In 1986, Dr. Robert Curran was the medical director of Cleveland Pneumatic Company. (U)

214. Dr. Curran never examined decedent between November 15, 1985 and the date of decedent's death. (U)

215. Dr. Curran had advised Cleveland at the time of decedent's initial employment that decedent had suffered from metastatic cancer and was a risk to employ.

216. Despite the information provided by Dr. Curran concerning decedent's health history, Cleveland chose to employ decedent.

217. Dr. Curran had the right to recommend to Cleveland whether or not to accept an employee back after a lengthy illness but Cleveland retained the ultimate right to determine whether such employee should be allowed to return to work.

218. In reliance on decedent's and Dr. Thomas's assertions of disability and inability to work, neither Cleveland Pneumatic Company, Pneumo Corp. nor Hancock asked decedent to submit to a medical examination by a physician of their choosing after he left work on November 15, 1985.

219. Dr. Thomas never advised Cleveland or Hancock at any time before Gridley's death that Gridley was capable of returning to work and performing all of the usual and customary duties of his job on a regular, full-time basis. (U)

220. Dr. Thomas never advised either Gridley or the Plaintiff that Gridley should return to work in Cleveland or that he was capable of returning to work in Cleveland.

221. Cleveland Pneumatic Company and Pneumo Corp. relied upon the representations of Gridley and Dr. F. Ardell Thomas found in the submissions dated February 10, 1986 and April 21, 1986, in paying salary continuance benefits to Joe Gridley.

222. All Defendants relied upon Joe Gridley's application for long term disability benefits, including Part B, the physician's statement, in determining that Gridley was qualified to receive long term disability benefits under the Pneumo long term disability plan.

223. Dr. Thomas confirmed that when he signed the attending physician's supplemental statement which was a part of the supplemental medical report on April 21, 1986, he believed the information found on that report to be true, correct and accurate and he continues to believe that the information found thereon is true and accurate.

224. Pneumo Corporation was the plan administrator under ERISA for the employee group health and life insurance plan funded by the John Hancock Group Life and Health Insurance Policy. (U)

225. The duties of plan administrator were performed for Pneumo Corporation by various employees at its corporate headquarters in Boston and by other employees, such as Defendants Smith and Borah at the locations of its various

corporation subsidiaries, such as Cleveland Pneumatic Company. (U)

226. At the time it provided the publication, "Your Group Insurance Plan," Plaintiff 14, to Cleveland, Hancock did not know that and should not reasonably have known that Cleveland would utilize that booklet as a summary plan description of benefits available under the John Hancock Group Life and Health Insurance Policy under which John Hancock provided health and life insurance benefits to employees of Cleveland Pneumatic Company.

227. By contract with Pneumo Corporation, Hancock processed and determined the validity of long-term disability benefits claims of Cleveland employees and paid those claims by check drawn on Pneumo Corporation's long-term disability trust checking account. (U)

228. Under the Hancock group policy, it was Hancock's as opposed to Cleveland Pneumatic Company's or Pneumo Corporation's obligation to pay life insurance claims, although the payment of a life insurance claim could have significant financial impact on the policyholder as a result of experience factors in computation of premiums payable by the policyholder and dividends payable to the policyholder. (U)

229. All claims up to $200,000 were to be paid by John Hancock out of premiums paid by Pneumo and if premiums for that year were insufficient to cover claims, out of future premiums.

230. If claims were less than the amount of premiums paid by Pneumo, John Hancock would return excess premiums to Pneumo in the form of a dividend.

231. In the view of the Defendants Smith and Borah decedent was required to return to work and work one full day

only in order to be entitled to receive life insurance benefits under the new plan effective January 1, 1986.

232. Effective January 1, 1986, Cleveland instituted a new program of prescription coverage which reduced the employee's deductible from $4 to $2 per prescription. (U)

233. The prescription plan had an "actively at work" requirement similar to that for life insurance.

234. Effective January 1, 1986, decedent received the benefit of the new prescription plan.

235. The new health insurance plan, which became effective January 1, 1986, also contained an "actively at work" requirement similar to the life insurance plan.

236. Under the new health insurance plan, each employee paid from payroll $10 per month per dependent for each dependent covered by the plan.

237. Under the old health insurance plan, which existed prior to January 1, 1986, there was no payment made by the employee for dependent coverage.

238. The $10 per dependent deduction was made from decedent's sick pay, effective January 1, 1986, for health insurance.

239. Plaintiff is a registered nurse with work experience in industrial nursing.

240. From at least November 15, 1985, until the date of the decedent's death, Plaintiff was familiar with decedent's activities on a daily basis.

241. Plaintiff was of the opinion that decedent could have performed all the usual and customary duties of his occupation on a regular full-time basis at some time or times during the

period of time from approximately mid-January until mid-March of 1986.

242. Cleveland ceased distributing copies of Plaintiff's Exhibit No. 14 entitled, "Your Group Insurance Plan 'salaried employees' " in December of 1985.

243. For the plan which became effective January 1, 1986, Plaintiff's Exhibit No. 19, entitled, "Employee Benefits summary," was considered to be the summary plan description.

244. Cleveland did not provide Gladys M. Gridley with notice, either in its letter denying benefits under the new plan or in its summary plan descriptions, Plaintiffs 14 and 19, of the availability of remedies for redress of claims which are denied in whole or in part as required by ERISA, 29 U.S.C. §1022(b).

III. Discussion.

Gridley has made three arguments in support of her claim for life insurance benefits under the new plan implemented by Cleveland on January 1, 1986. Her first argument is that she is entitled to recover benefits under the summary plan description, (Plaintiff's Exhibit 19), relating to the new plan. Next, Gridley claims that she is entitled to recover insurance benefits under the new plan based upon the policy of insurance itself as last amended prior to January 1, 1986. That amendment uses the phrase "actively at work" which is defined in the certificate booklet, (Plaintiff's Exhibit 14). Finally, Gridley claims that she is entitled to recover insurance benefits under the new plan based upon the theory of promissory estoppel.

Before considering the arguments presented in this case, we must first determine the appropriate standard of review. The recent case of Firestone Tire & Rubber Co. vs. Bruch, 109 S.Ct. 948 (1989), states that where a denial of benefits is

challenged under 29 U.S.C. §1132(a)(1)(B) as here the appropriate standard of review is a *de novo* standard unless the plan administrator or fiduciary is given discretionary authority to determine eligibility for benefits. There is no evidence that the plan administrator was given any discretionary authority to determine the decedent's eligibility for benefits and a *de novo* review is therefore appropriate.

Hancock argues that in exercising the *de novo* standard of review we may only consider the evidence which was before the plan fiduciary in the review of its denial of benefits under the new plan. No review by the plan fiduciaries was ever conducted. 29 U.S.C. §1133 requires that the plan administrator provide a beneficiary whose claim for benefits has been denied with adequate notice in writing of the reasons for such denial and must:

> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Cleveland concedes that Gridley was not given an opportunity to present evidence for review by the plan fiduciary. Normally, we would remand this matter to the trustee for the appropriate review. *See,* Wolf vs. National Shopmen Pension Fund, 728 F.2d 182 (3d Cir. 1984). There are, however, exceptions to the exhaustion requirement which apply in this case. A claimant seeking benefits under an ERISA plan may be excused from exhausting administrative remedies where resort to such administrative remedies would be futile or the remedy would be inadequate. Tomczyscyn vs. Teamsters, Local 115 Health and Welfare Fund, 590 F.Supp. 211, 213 (E.D. Pa. 1984) (citing to Amato vs. Bernard, 618 F.2d 559, 568 (9th Cir. 1980)). Not only was there no advice as to the right of appeal in the letter

notifying Gridley of the denial of benefits under the new plan, there is no notification to Gridley of an appeal process in the summary plan description or any other documents provided by Cleveland the plan administrator. ERISA, 29 U.S.C. §1022, requires that the summary plan description contain information about "remedies available under the plan for the redress of claims which are denied in whole or in part." There is no indication anywhere that any internal administrative remedies were available to Gridley at the time of the denial of benefits or that any such review is now available.

Additionally, Cleveland points out that the only additional evidence which Gridley has introduced pertains to assertions in testimony by F. Ardell Thomas, M.D., that Joseph R. Gridley could have returned to work for a limited period of time and that this new evidence only minimally strengthens Gridley's argument. Cleveland states that remand to the Plan fiduciary would therefore be a useless formality. *See,* Wardle vs. Central States, Etc., 627 F.2d 820 (7th Cir. 1980) We are of the view that Cleveland's noncompliance with ERISA's review requirements and the admission by Cleveland that a remand would only be a "useless formality" excuses Gridley from the necessity of exhausting internal administrative remedies. Hancock argues that it should not be subject to a broader standard of review because of Cleveland's non-compliance with ERISA review requirements. Hancock also argues, however, that remand would be futile because the additional evidence of Dr. Thomas's opinions that Mr. Gridley could have returned to work after January 1, 1986, is useless. Both of the Defendants have indicated that the later assertions of Dr. Thomas regarding Mr. Gridley's ability to return to work would not alter their initial decision. *Cf., Tomczyscyn,* 590 F.Supp. 211, 215 (E.D. Pa. 1984) (Court was unable to say that

trustees would have affirmed the initial decision had they had an opportunity to review it.) In view of the above discussion, we will review all of the evidence presented to us during trial.

In support of her right to recover life insurance benefits under the new plan initiated January 1, 1986, Gridley first asserts that she is entitled to recover under the summary plan description entitled "Employee Benefits Summary," (Plaintiff's Exhibit No. 19). 29 U.S.C. §1022 requires that a summary plan description of an employee benefits plan must be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." Additionally, part (b) of this section requires that the summary plan description contain " ... circumstances which may result in disqualification, ineligibility, or denial or loss of benefits ..." For the plan which became effective January 1, 1986, Cleveland considered Plaintiff's exhibit No. 19, entitled, "Employee Benefits Summary," to be the summary plan description. This document in no way complies with ERISA requirements as to ineligibility. The Survivor Security Section of the "Employee Benefits Summary" states that the employee is "automatically eligible to participate in our life insurance plans on your first day of employment with the company." Nowhere in the booklet is there any statement of circumstances which may result in disqualification or ineligibility for benefits. The only restriction placed on the receipt of increased benefits is that the individual be employed with the company. It is undisputed that Mr. Gridley was still an employee with the company from January 1986 until the time of his death.

Cleveland maintains first that the Gridleys were put on notice that Mr. Gridley was required to be "actively at work"

sometime after January 1, 1986, in order to be eligible for increased benefits under the new plan. Cleveland's argument is that Mr. Gridley received the document "Your Group Insurance Plan", (Plaintiffs' Exhibit No. 14) when he was first employed with the Company. Cleveland considered this booklet to be its summary plan description prior to the implementation of the increased life insurance benefits on January 1, 1986. This booklet contains the provision that for an employee not "actively at work" an increase in benefits "will not become effective until the date you return to active work." This booklet goes on to define "actively at work" as:

> "actively at work"—an employee shall be considered "actively at work" if he reports for work on the date in question at his usual place of employment with his Employer and such usual place of employment is outside of his home, and if when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular, full-time basis. If an employee does not so report, or if his usual place of employment with his Employer is not outside of his home, he shall be considered "actively at work" if at any time on the date in question he is neither (i) hospital confined, nor (ii) disabled to a degree that he could not then have reported to a place of employment outside of his home and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

Cleveland asserts that the fact that Mr. Gridley at one time received a copy of this booklet placed him on notice of the requirement that in order to be eligible for an increase in benefits he was required to be physically at work at some time after those increased benefits came into effect. We do not find his argument convincing. Cleveland ceased distributing cop-

ies of "Your Group Insurance Plan", (Plaintiff's Exhibit No. 14), in December of 1985. If this was at one time considered Cleveland's summary plan description, it was no longer considered as such once it stopped distributing the booklet and began distributing the "Employee Benefits Summary", (Plaintiff's Exhibit No. 19) in its place. If Plaintiff's Exhibit No. 19 was only considered a summary of the new benefits available after January 1, 1986, as Cleveland asserts, it should not have discontinued distribution of Plaintiff's Exhibit No. 14 in reliance on Plaintiff's Exhibit No. 19 as the new summary plan description. The "Employee Benefits Summary," Plaintiff's Exhibit No. 19, states that the employee is "automatically eligible" for the new benefits and we are of the view that despite the existence of Plaintiff's Exhibit No. 14 it was reasonable for Cleveland's employees to believe that they were eligible for the increased benefits regardless of whether they were currently at work or not. "[A] summary plan description must not mislead, misinform, or fail to inform participants and beneficiaries of the Plan." Genter vs. Acme Scale & Supply Co., 776 F.2d 1180, 1185 (3d Cir. 1985). Cleveland's failure to provide information which may have affected Mr. Gridley's eligibility for new benefits is a violation of ERISA, 29 U.S.C. §1022(a)(1). Because of these violations, he did not have notice of any conditions and is therefore entitled to benefits as described in Plaintiff's Exhibit No. 19.

Cleveland further argues that the Gridleys were provided with additional notice that Mr. Gridley must return to work before becoming eligible for the new benefits when Cleveland distributed the enrollment card (Plaintiff's Exhibit No. 24) at the meeting of November 25, 1985. This meeting was intended to inform Cleveland's employees of the new benefits available to them including optional life insurance. Gladys M.

Gridley was told at the November 25, 1985, meeting that the card should be signed and returned to the company so that appropriate deductions for the selected insurance plan could be made. There was no mention at the meeting that any employee must be present at work before signing and returning the card. The final paragraph on the card before Mr. Gridley's signature states:

> I certify that I am an active, full-time employee of the above-named employer and work a regularly scheduled work week with such employer. I understand that if I do not meet these requirements, I am not eligible for any insurance. I certify I have read and understood the above provisions.

This, Cleveland maintains, placed Mr. Gridley on notice that he must be "actively at work" in order to qualify for the increased benefits selected by this enrollment card. The card, however, is not accurate in that it states that if the employee does not work a regularly scheduled work week he is not eligible for any insurance. There is no such requirement in the original policy, in any amendment thereto, or in either plan summary. Mr. Gridley was clearly eligible for health insurance benefits, salary continuance benefits, long term disability benefits, and at the very least, life insurance benefits under the old plan. Additionally, at the meeting of November 25, 1985, Mrs. Gridley was encouraged to have Mr. Gridley complete and sign the enrollment card as soon as possible so that the proper deductions could be made under the new benefits plan. Mr. Gridley completed the enrollment card and returned it to Cleveland. Cleveland routinely processed the card and eventually began payroll deductions from Mr. Gridley's checks according to the schedule provided in the new summary plan description (Plaintiff's exhibit No. 19). Mr. Gridley's execution

of the enrollment card, (Plaintiff's Exhibit No. 24), did not put him on notice that he was required to return to work in order to be eligible for the new benefits plan.

Hancock argues that only the Insurance Policy itself controls the determination of whether Gridley is entitled to life insurance benefits under the new plan. In compliance with the contract between Hancock and Pneumo Corporation, the parent company of Cleveland, Hancock provided a certificate booklet (Plaintiff's Exhibit 14) to be distributed to Cleveland's employees. This certificate booklet was used by Cleveland as its original summary plan description; however, that was not the purpose for which it was drafted by Hancock. Although Hancock did not issue a new certificate booklet to Cleveland which included the January 1, 1986, amendments to the policy, this was a contractual obligation to the plan administrator and not an obligation to the employees. Additionally, Hancock had no hand in the drafting of the new summary plan description (Plaintiff's Exhibit, No. 19). We determined that Gridley is entitled to life insurance benefits under the new plan based upon the omission of any disqualifying factors presented in that new summary plan description. Had Cleveland included in its new summary plan description any "actively at work" requirement as a basis for eligibility, we would be obliged to consider what the term "actively at work" means; however, no such condition was present in the new summary plan description distributed by Cleveland. The omission of the "actively at work" requirement was Cleveland's and not Hancock's. The new summary plan description, (Plaintiff's Exhibit No. 19), informed Mr. Gridley that he was eligible for benefits under the new plan merely by virtue of being an employee. Whether Hancock considered Mr. Gridley not to be "actively at work" is not relevant. We are of the view that Hancock is not liable

to Gridley for the increased benefits under the new benefits plan.

We are also of the view that Defendants Smith and Borah as employees of Cleveland exercised no discretionary authority with regards to a beneficiary's receipt of benefits. In fact, Smith and Borah submitted Gridley's application for benefits under the new plan and admitted that they were instructed by the then Manager of Employee Benefits for Pneumo Corporation to permit Hancock to make the final decision as to the amount of benefits to which Gridley was entitled. Although they were aware that there was an "actively at work" requirement which might have precluded Mr. Gridley from eligibility for life insurance benefits under the new plan and it may have been advisable for them to inform Mr. Gridley of this requirement we cannot say that they were under an obligation to do so. We therefore do not see how either Smith or Borah can be held individually liable to Gridley. Cleveland was responsible for informing Mr. Gridley of any condition precluding eligibility in its summary plan description and it did not do so. Cleveland is therefore the only Defendant liable to Gridley for the increased benefits under the new plan based upon its "Employee Benefits Summary," Plaintiffs Exhibit No. 19.

Gridley's second argument is that she is entitled to recover insurance benefits under the new plan based upon the policy of insurance itself as last amended prior to January 1, 1986. ERISA, 29 U.S.C. §1132(a)(1)(B) provides that a beneficiary of an employee benefits plan may bring a civil action:

> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

Gridley argues that although Mr. Gridley was never physically present at work after November 15, 1985, he meets the definition of "actively at work" as stated in the certificate booklet, Plaintiff's Exhibit No. 14, issued by Cleveland and Hancock. Her assertion is that the certificate is required by the insurance contract to be prepared by Hancock and distributed to all employees who are entitled to benefits under the insurance contract and therefore the definition of "actively at work" contained within the certificate cannot be ignored.

In order to determine whether Gridley is entitled to benefits under the terms of the plan, we must first determine of what documents the plan is comprised. Gridley contends that the plan consists of the original policy of insurance, the amendments, the certificate booklet (Plaintiff's Exhibit No. 14) and the most recent summary plan description (Plaintiff's Exhibit No. 19). Cleveland agrees. Hancock contends, however, that the policy itself states of what the policy is comprised. The policy provides:

> *Entire Contract*
>
> This policy, the application of the Policyholder, a copy of which is attached hereto and made a part hereof, and the individual applications, if any, of the employees insured shall constitute the entire contract.

Hancock argues that neither the certificate of insurance containing the definition of "actively at work" nor the summary plan description are part of the policy of insurance and that the policy itself has an "actually at work" requirement which is clear on its face and requires no further explanation. The policy states:

> EFFECTIVE DATE OF INSURANCE. If the employee's insurance does not become effective on the date he

> becomes eligible because he is not actually at work, his insurance will become effective on the date he actually returns to work.

and further provides:

> Each Employee shall be classified and the amount of his insurance determined on each of the following dates:
>
> 5. On the effective date of each new benefit or of the extension of any existing benefit to a new class of employees;
>
> If on the date the amount of the Employee's Insurance is determined in accordance with the foregoing the Employee is not actually at work for his Employer, he shall not be entitled to any increase in insurance or any additional benefits for which he may be eligible until he actually returns to work.

According to the policy of insurance neither the certificate booklet nor the summary plan description are part of the insurance contract between Pneumo Corporation and Hancock. There is still question, however, as to whether it is appropriate for us to consider these other documents. The policy states that it is governed by the laws of the jurisdiction of issue which in this case would be Massachusetts. Therefore, in determining whether we may consider evidence other than the plan itself in defining a material term we will look to Massachusetts law.

Massachusetts law would allow us to consider the certificate in a case

> Where insurance certificates create ambiguities in the extent of coverage, and particularly where conflicts exist between the terms of the certificate and the group policy,

> the language of the certificate, where more favorable to the insured, prevails.

Kirkpatrick vs. Boston Mutual Life Insurance Company, 393 Mass. 640, 473 N.E. 2d 173 (1985). The court in *Kirkpatrick* considered the insurance certificate despite the fact that the certificate contained language which stated that the certificate did not "... void any of the terms and conditions outlined in the policy..." The Court reasoned that the certificate is drafted by the insurer to be issued to the employee and the insurer should therefore not be permitted to deny that the language of the certificate does not express the terms of the policy. *Kirkpatrick*, 473 N.E. 2d at 178. We find the reasoning of *Kirkpatrick* convincing and shall consider the definition of "actively at work" as defined in the certificate booklet (Plaintiff's Exhibit No. 14) issued by Hancock. The summary plan description (Plaintiff's Exhibit No. 19) on the other hand, has no "actively at work" requirement and therefore creates no conflict in terms. In addition, the new summary plan description was not drafted or issued by Hancock and we will not consider it in interpreting the terms of the policy as against Hancock.

The certificate booklet provides that an employee may be considered "actively at work" if he is neither hospital confined nor:

> disabled to a degree that he could not then have reported to a place of employment outside of his home and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

We must first determine whether under the above definition Mr. Gridley could have been considered "actively at work" and thus eligible for benefits. Under this definition, an employee may be found "actively at work" without being physically present at work; however, he must in some way show that he

could have performed all of his "usual and customary duties of his occupation on a regular, full-time basis." We have heard much evidence with regards to whether Mr. Gridley could have performed his duties had he returned to work at some time prior to his death.

Mr. Gridley was a manufacturing engineer for Cleveland. His job required him to climb a flight of stairs from the machine shop to his desk, required carrying IBM printouts weighing 10 to 40 pounds, carrying 10 pound weights frequently for distances of up to 20 feet and 40 pounds for distances of up to 2 feet, walking, standing and sitting. His regular work week was eight hours per day, five days per week, and an occasional Saturday. Gridley argues that Mr. Gridley's condition was such that he could have been physically present at his place of employment performing all the usual and customary duties of his job on a regular, full-time basis from approximately mid-January of 1986 until approximately early March of 1986. She stated that she and her husband took several extended automobile trips in which Mr. Gridley shared the driving and that he was able to climb the stairs at home and do other jobs around the house.

Both Cleveland and Hancock contend, however, that the information they received in Joe Gridley's applications for salary continuance benefits and long-term disability benefits stated that his condition was deteriorating, he was experiencing fatigue, shortness of breath upon slight exertion, bouts of nausea, difficulty in eating, and continual weight loss. While we may agree that Mr. Gridley could have returned to work at some point on a limited basis, that is not what the definition of "actively at work" requires. It is possible that Mr. Gridley could have performed all of the usual customary duties of his occupation; however, it is our opinion that he could not have

done so on a regular, full-time basis. The term "regular" connotes more than one day or even a few days. It is probable that Cleveland would have considered that Gridley would have become eligible for benefits under the new plan had Mr. Gridley returned to work for even one day after January 1, 1986. However, the "actively at work" condition requires more than a mere return to work. We are of the view that Mr. Gridley was not capable of working his regular eight hours per day, five days per week.

In addition to Mr. Gridley's ability to return to work on a regular, full-time basis, Gridley must show that she and her husband in some way relied upon their interpretation of the definition of "actively at work" contained in the certificate booklet. Gladys Gridley admits that she never discussed the "actively at work" condition with Mr. Gridley and was not even aware of the certificate booklet until after this action was filed. In view of this, Gridley is not eligible for benefits under the new plan based upon the policy of insurance and the certificate booklet defining the term "actively at work."

Gridley's final argument is that she is entitled to recover insurance benefits under the new plan based upon a theory of promissory estoppel. Before considering Gridley's argument, we must determine the threshold question of whether a claim based upon a theory of promissory estoppel is preempted by ERISA. 29 U.S.C. §1144 provides that:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Under this section, state law claims are preempted by ERISA if they "relate to" an employee benefit plan. Under the civil enforcement provisions of 29 U.S.C. §1132(a), a beneficiary may sue to recover benefits due under the plan. Gridley's promissory estoppel argument, however, is not that she is entitled to benefits under the plan itself, but rather, is entitled to recover the benefits to which they led her to believe she was entitled. It was Congress's intent that ERISA's civil enforcement scheme be exclusive. Pilot Life Insurance Company vs. Dedeaux, 107 S.Ct. 1549, 1558 (1987). The claim against the insurance company in *Pilot Life* alleged the improper processing of a claim for benefits under an ERISA regulated plan and was clearly "related to" the plan. The Court concluded that ERISA's civil enforcement provisions were sufficient to preclude the state law claim in that case. Gridley is not seeking to enforce benefit rights under the plan but bases her claim upon the alleged misleading actions and omissions of Cleveland employees. Gridley argues that because she was led to believe that she would be entitled to the increased benefits Cleveland and Hancock are estopped from later denying such benefits regardless of whether she is eligible under the plan. We are of the view that a claim of promissory estoppel remains viable. *See* Pizlo vs. Bethlehem Steel Corp., 884 F.2d 116, 120 (4th Cir. 1989); Perry vs. P•I•E Nationwide, Inc., 872 F.2d 157, 162 (6th Cir. 1989). Pane vs. RCA, 868 F.2d 631, 638 (3d Cir. 1989); Rosen vs. Hotel & Restaurant Employees, Etc., 637 F.2d 592, 597-98 (3d Cir.), *cert. denied*, 454 U.S. 898 (1981).

In order to prevail on a theory of promissory estoppel, Gridley must show that there was (1) a material misrepresentation, (2) that she reasonably relied upon that misrepresentation, and (3) damage resulting from that misrepresentation. Rosen vs. Hotel and Restaurant Employees and Bartenders

Union, 637 F.2d 592 (3d Cir.), *cert. denied,* 454 U.S. 898 (1981); Pane vs. RCA Corporation, 868 F.2d 631, 638 (3d Cir. 1989). Gridley argues that material misrepresentations began with the November, 1985, meeting in which employees of Cleveland were informed of increased benefits available under the new plan. Gridley contends that despite Smith's knowledge of Mr. Gridley's illness and his absence from work, there was never any indication that the Gridleys would be ineligible for benefits under the new plan. Both Smith and Borah were aware that Mr. Gridley had opted for the increased benefits and Cleveland's payroll department made deductions from Mr. Gridley's checks based upon the schedule for increased benefits. When incorrect deductions were being made, Gridley had phone conversations with several Cleveland employees and was directed to send additional money to cover the premiums for the increased benefits. Gridley asserts that she reasonably relied upon Cleveland's and its employees' failure to disclose the "actively at work" requirement, the acceptance of premiums by Cleveland and Hancock, and the failure on the part of Cleveland to indicate to Mr. Gridley that there was any question concerning his eligibility. As a result of such reliance, Gridley asserts that she has been harmed in an amount equal to the difference between benefits available under the new plan and those available under the old plan.

Cleveland contends that there was no material misrepresentation or omission because Cleveland's employees did not have a duty to advise Gridley orally of the "actively at work" condition. Cleveland further contends that there was sufficient disclosure of the "actively at work" condition through the distribution of the enrollment card and the certificate booklet which Cleveland issued as its summary plan description prior to December 1985, (Plaintiff's Exhibit No. 14). Cleveland

further asserts that the Gridleys chose not to inquire about that issue and that ERISA imposed no obligation to provide individualized notice or benefit analysis to plan participants. Cleveland also denies that any reliance upon the failure to inform the Gridleys of the "actively at work" requirement was reasonable in view of the fact that all plan documents and summaries contained a disclaimer which indicated that the formal written plan description (the insurance policy) would control and also that Mr. Gridley was given notice of the eligibility condition through the certificate booklet and the enrollment card. Cleveland finally argues that Gridley cannot demonstrate any damage or prejudice from reliance on misrepresentations or omissions of Cleveland. This argument is based upon Cleveland's assertion that even if Mr. Gridley had been informed of the "actively at work" eligibility condition he suffered no prejudice because he would not have been able to meet that condition. In addition, Cleveland argues that reliance based upon the acceptance of premiums is not reasonable.

We are of the view that the actions of Cleveland employees did indicate that the Gridleys were eligible for benefits under the new plan and that reliance upon the actions of these employees was reasonable. We are, however, unable to conclude that the Gridleys were prejudiced or damaged by their reliance on the actions of Cleveland employees. If Mr. Gridley was informed that there was some question as to his eligibility because of an "actively at work" condition, he would have been unable to fulfill that requirement. Even though in Smith's opinion it would have only taken a return to work of one day after January 1, 1986, for Mr. Gridley to qualify this is not what the term "actively at work" requires. In addition, Gridley has offered no evidence that Mr. Gridley's and her reliance on

Cleveland's representations of eligibility prevented them from taking other courses of action. We conclude that we may not hold Cleveland or its employees liable based upon a theory of promissory estoppel.

Hancock argues that the only representation that it made to Mr. Gridley was that he was required to be "actively at work" in order to be eligible for increased benefits. Gladys Gridley cannot assert that she and her husband or either of them relied upon this definition. We are of the view that Hancock cannot be held liable under a theory of promissory estoppel.

IV. Conclusions of Law.

1. Pneumo Corporation contracted with John Hancock Mutual Life Insurance Company to provide certain benefits for Cleveland Pneumatic Company's salaried, exempt employees, including life insurance, medical, surgical and hospital-care insurance, long-term disability insurance and prescription insurance, all constituting an employee welfare benefit plan or welfare plan subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. §1001, *et seq.*

2. The employer with respect to the above employee welfare benefit plan was Cleveland Pneumatic Company. *See,* 29 U.S.C. §1002(5).

3. The employee for purposes of this case was Joseph R. Gridley (decedent). *See,* 29 U.S.C. §1002(6).

4. Decedent was a participant in the Pneumo employee welfare benefit plan as that term is defined in 29 U.S.C. §1002(7).

5. Gladys M. Gridley was a beneficiary of the Pneumo employee welfare benefit plan as that term is defined at 29 U.S.C. §1002(8).

6. The life insurance benefit plan provided to decedent by Pneumo through a contract of insurance with Hancock was subject to the provisions of ERISA.

7. The plan administrator of the Cleveland Pneumatic Company group life insurance plan for salaried, exempt employees was Cleveland Pneumatic Company and its parent, Pneumo Corporation.

8. The insurer of the Cleveland Pneumatic Company group life insurance plan for salaried, exempt employees was John Hancock Mutual Life Insurance Company.

9. Plaintiff's Exhibit 19 was the summary plan description for the Cleveland Pneumatic Company Employee Benefit Plan to be effective January 1, 1986.

10. The Summary Plan Description, Plaintiff's Exhibit 19, failed to apprise decedent and Plaintiff of their rights under the plan in that it failed to provide information concerning the plan's requirements respecting eligibility for participation in benefits and failed to set forth accurately and comprehensively in a manner calculated to be understood by the average plan participant the requirement that an employee must be "actively at work" before becoming eligible for the new life insurance benefits to be effective January 1, 1986.

11. Decedent met all of the requirements respecting eligibility for participation in benefits as set forth in the Summary Plan Description, Plaintiff's Exhibit 19, with respect to both basic and supplemental life insurance coverages and his named beneficiary, Plaintiff herein, is entitled to receive from Cleveland Pneumatic Company those benefits under the Employee Benefit Plan, effective January 1, 1986, in the full amount of $202,000.00.

12. Cleveland Pneumatic Company is liable to Gladys M. Gridley for the difference between life insurance benefits

under the old plan and those under the new plan effective January 1, 1986.

13. Cleveland Pneumatic Company is liable to the Plaintiff in the amount of $202,000.00 less $68,000.00, amounts paid to her under the prior plan.

14. Hancock is not liable for any procedural violations of ERISA because it never intended, nor was ever advised, that any of its documents were to be used as formal plan descriptions or summary plan descriptions under ERISA.

15. The definition of the phrase "actively at work" contained in the employee's insurance certificate, Plaintiff's Exhibit 14, controls with respect to the definition of the contract condition, "actively at work."

16. Prior to his death, the decedent was not "actively at work" as that phrase is defined in Plaintiff's Exhibit 14.

17. The Defendants Smith, Borah and John Hancock Mutual Life Insurance Company are not liable to Gridley for increased benefits which came into effect January 1, 1986, under the terms of the insurance policy.

18. The Gridleys were not prejudiced or damaged by their reliance on the actions of Cleveland's employees.

19. The Defendants are not liable to Gridley for payment of increased benefits which became effective January 1, 1986, based upon a theory of promissory estoppel.

20. Defendants John Hancock Mutual Life Insurance Company, Marjorie Ann Smith, and Patricia Borah are not liable to Gladys M. Gridley for life insurance benefits under the plan which came into effect on January 1, 1986.

An appropriate order will be entered.

s/MUIR, U.S. District Judge

DATED: February 21, 1990

FILED
FEB. 21 1990
DONALD R. BERRY, Clerk
PER bp
DEPUTY CLERK

UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

GLADYS M. GRIDLEY,

Plaintiff

vs.

CLEVELAND PNEUMATIC COMPANY, A subsidiary of PNEUMO CORPORATION, a subsidiary of IC INDUSTRIES, et al.,

Defendants

Civil No. 88-0908

Complaint Filed 6/15/88

(Judge Muir)

ORDER

1. Judgment shall be entered in favor of Gladys M. Gridley and against Cleveland Pneumatic Company in the amount of $134,000.

2. Judgment shall be entered in favor of John Hancock Mutual Life Insurance Company, Marjorie Ann Smith, and Patricia Borah.

s/MUIR: U.S. District Judge

DATED: February 21, 1990

MM:as

FILED
FEB. 21, 1990
DONALD R. BERRY, Clerk
PER bp
DEPUTY CLERK

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA
JUDGMENT IN A CIVIL CASE
GLADYS M. GRIDLEY
V.
CLEVELAND PNEUMATIC CO., MARJORIE ANN SMITH, PATRICIA BORAH, JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that judgment be and hereby is entered in favor of Plaintiff Gladys M. Gridley and against Defendant Cleveland Pneumatic Company in the amount of $134,000.00.

IT IS FURTHER ORDERED AND ADJUDGED that judgment be and hereby is entered in favor of John Hancock Mutual Life Insurance Company, Marjorie Ann Smith and Patricia Borah.

Date: February 21, 1990

Clerk: Donald R. Berry
(By) Barbara Poust, Deputy Clerk

[Printer's note: Appendix reset from original copy including errata, if any.]

Supreme Court, U.S.
FILED
JUN 4 1991
OFFICE OF THE CLERK

(2)

No. 90-1711

In The

Supreme Court of the United States

October Term, 1990

GLADYS M. GRIDLEY,

Petitioner,

v.

CLEVELAND PNEUMATIC COMPANY, et al.,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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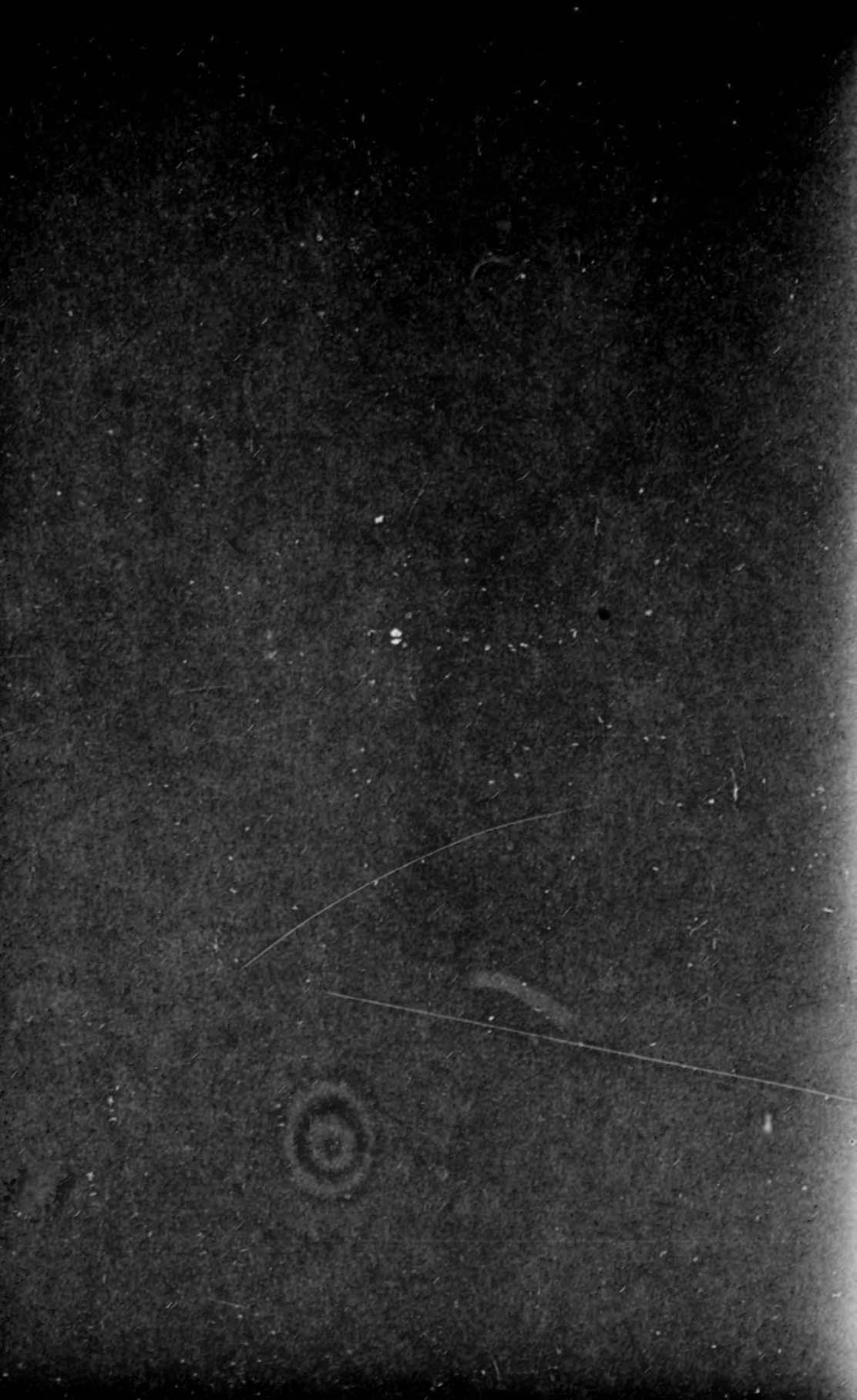

QUESTIONS PRESENTED

1. Whether an employee benefit brochure distributed by a plan administrator to employees constitutes a summary plan description under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, et seq., when the brochure summarizes benefits and the plan administrator testifies that the brochure was considered by it to be the summary plan description for a new benefits package?

2. Whether ERISA affords to Petitioner, under the facts of this case, a remedy for the failure of the plan administrator to comply with the statutory mandate to supply a summary plan description which contains conditions of eligibility, disqualification and denial or loss of benefits?

PARTIES IN THE COURTS BELOW

GLADYS M. GRIDLEY,

Plaintiff

vs.

CLEVELAND PNEUMATIC COMPANY*, a subsidiary of Pneumo Corporation, a subsidiary of IC Industries; MARJORIE ANN SMITH, individually and as manager of Employee Benefits and Services; PATRICIA BORAH, individually and as Employee Benefits Administrator; JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY,

Defendants

* At the present time Cleveland Pneumatic Company is wholly owned by Pneumo Abex Corp., which is wholly owned by Henley Group, Inc. and Wasserstein, Perella & Company, Inc., acting through a joint venture named P.A. Holdings.

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OPINIONS AND JUDGMENTS IN THE COURT BELOW

Prior to the trial of this action, the District Court for the Middle District of Pennsylvania issued an Opinion and Order which is reported at 127 F.R.D. 102 (M.D.Pa. 1990), and which has no pertinence to the questions presented to this Court for review. The District Court's Opinion and Final Order, issued after the trial, has not been officially reported, and is reproduced in the Appendix to the Petitioner's Petition for Writ of Certiorari. The Third Circuit Court of Appeals reversed the District Court with an Opinion, reported at 924 F.2d 1310 (3d Cir. 1991).

STATUTES INVOLVED

Employee Retirement Income Security Act (ERISA) § 101, 29 U.S.C. § 1001

Set forth in Petition for Writ of Certiorari

ERISA § 102, 29 U.S.C. § 1022

Set forth in Petition for Writ of Certiorari

ERISA § 104(b)(1), 29 U.S.C. § 1024(b)(1)

* * *

If there is a modification or change described in Section 1022(a)(1) of this title, a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan.

ERISA § 502(a), 29 U.S.C. § 1132(a)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section; or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under Section 409 [29 U.S.C. § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 U.S.C.S. § 1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (i).

ERISA § 502(c), 29 U.S.C. § 1132(c)

(c) Administrator's refusal to supply requested information. Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

STATEMENT OF THE CASE

The Petitioner's statement of the case is accurate, but omits certain matters which Respondent believes to be pertinent to the Court's consideration of the Petition.

The District Court begins its discussion of the case by noting that Mrs. Gridley made three arguments in support of her claim for increased life insurance benefits.

> Her first argument is that she is entitled to recover benefits under the summary plan description, (Plaintiff's Exhibit 19), relating to the new plan. Next, Gridley claims that she is entitled to recover insurance benefits under the new plan based upon the policy of insurance itself as last amended prior to January 1, 1986. That amendment uses the phrase "actively at work" which is defined in the certificate booklet, (Plaintiff's Exhibit 14). Finally, Gridley claims that she is entitled to recover insurance benefits under the new plan based upon the theory of promissory estoppel.
>
> (Appendix attached to Petition for Writ of Certiorari [hereinafter "App."] p. 71a)

The District Court holds that Mrs. Gridley is entitled to the increased life insurance benefit on the grounds that the Employee Benefits Summary, (Plaintiff's Exhibit 19, referred to by the Court of Appeals as the "new overview brochure"), distributed to Plaintiff, was a summary plan description which failed to set forth the "actively at work" condition, precluding participation in benefit increases until the employee was "actively at work" (App. p. 76a).

The District Court gives no indication of what section of ERISA provides the remedy the Court grants for a violation of the ERISA requirements for summary plan descriptions, set forth at 29 U.S.C. § 1022(b).

The Court goes on to analyze Petitioner's second argument:

> Gridley's second argument is that she is entitled to recover insurance benefits under the new plan based upon the policy of insurance itself as last amended prior to January 1, 1986. ERISA, 29 U.S.C. § 1132(a)(1)(B) provides that a beneficiary of an employee benefits plan may bring a civil action:
>
> > (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (App. p. 79a)

The District Court finds that the employee group life insurance plan comprises the group life insurance policy issued by John Hancock and the group insurance certificate booklet entitled "Your Group Insurance Plan," (Plaintiff's Exhibit 14), delivered to the employee at the time of his first employment, in May 1985 (App. pp. 35a, 81a-82a). The group life insurance policy provided:

> If on the date the amount of the Employee's insurance is determined in accordance with the foregoing, the Employee is not actually at work for his Employer, he shall not be entitled to any increase in insurance or any additional benefits for which he may be eligible until he actually returns to work.
>
> (App. p. 31a)

In addition, the certificate booklet "Your Group Insurance Plan", Plaintiff's Exhibit 14, provided:

> WHEN DOES INSURANCE BECOME EFFECTIVE.
>
> For you – insurance becomes effective on the date you've become eligible, provided you are actively at work on said date, otherwise on the first date thereafter on which you are actively at work.
>
> (App. p. 34a)

The certificate booklet went on to set forth a definition of "actively at work". It was intended to describe the terms of the policy (App. p. 34a). Thus it is undisputed that the employee Joseph Gridley did receive a booklet containing a detailed description of the terms of the group life insurance plan, including the "actively at work" condition on eligibility for benefit increases.

The District Court concludes that Gridley is not entitled to recover benefits due under the terms of the plan, pursuant to 29 U.S.C. § 1132(a)(1)(B), in that Gridley was never "actively at work", on or after the benefit increase.

The District Court then addresses Gridley's final argument, that she is entitled to recover the increased life insurance benefit under a theory of promissory estoppel. The District Court sets forth the elements of promissory estoppel:

> Gridley must show that there was (1) a material misrepresentation, (2) that she reasonably relied upon that misrepresentation, (3) damage resulting from that misrepresentation.
>
> (App. p. 85a)

The Court concludes:

> We are of the view that the actions of Cleveland employees did indicate that the Gridleys were eligible for benefits under the new plan and that reliance upon the actions of these employees was reasonable. We are, however, unable to conclude that the Gridleys were prejudiced or damaged by their reliance on the actions of Cleveland employees. If Mr. Gridley was informed that there was some question as to his eligibility because of an "actively-at work" condition, he would have been unable to fulfill that requirement.

(App. p. 87a)

Thus the sole basis for the Court's imposition of liability on Cleveland Pneumatic Company flows from the District Court's conclusion that the new overview brochure, distributed to the employee, was a summary plan description, and that that summary plan description failed to set forth the "actively at work" condition on receipt of increased life insurance benefits. The Court imposes liability notwithstanding the fact that the eligibility condition at issue was disclosed in writing to the employee, in a booklet concerning the group life insurance program which he received prior to the increase in benefits. The Court fails to identify any provision of ERISA which authorizes the relief the Court grants. The Court accepts the contention that the group life insurance plan does contain an "actively at work" condition, and rejects the employee's claim for benefits under 29 U.S.C. § 1132(a)(1)(B). Finally, the Court holds that the employee suffered no damage by reason of the failure of the new overview brochure to disclose the "actively at work"

condition, since, even if the employee had known of the condition, he would not have been capable of compliance.

SUMMARY OF THE ARGUMENT

The employee Joseph Gridley was provided with a booklet, summarizing the provisions of the group life insurance plan, including the "actively at work" condition on eligibility for participation in increased benefits, at the time he was first employed. The employer contended that the document he was subsequently provided with, the new overview brochure, was a summary of material modifications of the plan, and not a summary plan description. In reversing the District Court's finding that the new overview brochure was a summary plan description, the Court of Appeals engaged in a detailed factual analysis. This fact-specific analysis limits the applicability of the instant holding to the facts of this case, and renders this case an inappropriate vehicle for pronouncements of national import concerning ERISA.

Mrs. Gridley failed to prove any prejudice or detriment resulting from disclosure violations. The Court of Appeal's rejection of a remedy for disclosure violations in the absence of damage to the plan participant is consistent with the limited remedies provided by Congress in ERISA, and with the decisions of this Court and of other Circuit Courts.

ARGUMENT

1. The United States Court of Appeals for the Third Circuit's conclusion that the new overview brochure provided to Plaintiff was not a summary plan description has little impact beyond the facts of this case.

Mrs. Gridley contends that the new overview brochure, Plaintiff's Exhibit 19, provided to her subsequent to her husband's departure from work with a terminal illness, was a "summary plan description", violative of the requirements for summary plan descriptions, set forth in 29 U.S.C. § 1022(b). She bases that claim primarily on the contention that the new overview brochure must have been the summary plan description, since there was no other document distributed to herself or her husband which complied with requirements set forth in 29 U.S.C. § 1022(b) for summary plan descriptions. She seeks to have the Court ignore the fact that, at the time he was first employed, in May 1985 (just six months prior to his departure from work with a terminal illness), Mr. Gridley was provided with the insurance certificate booklet "Your Group Insurance Plan", Plaintiff's Exhibit 14. As noted by the Court of Appeals, this booklet contained "a lengthy description of the terms of the group insurance policy" (App. p. 5a). Admittedly, this booklet lacked much of the information required of ERISA for a summary plan description. However, in one respect, critical to this case, it did comply with the summary plan description requirements set forth at 29 U.S.C. § 1022(b). The booklet did set forth the pertinent condition on eligibility for participation in benefit increases, the "actively at work" condition.

In addition, at the time of first employment Joseph Gridley signed an application card, applying for the group life insurance coverage, which stated, directly above his signature:

> I certify that I am an active, full-time employee of the above-named employer and work a regularly scheduled work week with such employer. I understand that if I do not meet these requirements I am not eligible for any insurance. I certify that I have read and understood the above provisions.

(App. pp. 37a-38a, Finding of Fact 46)

In November 1986, Joseph Gridley signed an identical application card, applying for the increased life insurance benefit. That card contained the same certification, directly above his signature (App. p. 43a, Finding of Fact 73). He was off work on sick leave at the time he signed that card (App. p. 58a, Finding of Fact 162).

The group life insurance plan at issue was modified as of January 1, 1986. As far as group life insurance was concerned, the modification was solely limited to increasing the dollar amount of the benefits available. Those benefits continued to be provided pursuant to and subject to the conditions of John Hancock's group life and health insurance policy. The District Court refers occasionally to the "new plan" taking effect January 1, 1986, but actually what occurred was a modification of the old plan.

29 U.S.C. § 1022(a)(1) provides, in its last sentence:

> A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated

> to be understood by the average plan participant and shall be furnished in accordance with § 1024(b)(1) of this title.

The cited section, 29 U.S.C. § 1024(b)(1) provides, in pertinent part:

> If there is a modification or change described in § 1022(a)(1) of this title, a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan.

While ERISA imposes detailed requirements concerning the contents of a summary plan description, it does not specify what need be contained in a summary of material modifications of a plan, other than to state that material modifications be summarized. There is no statutory requirement that a summary of material modifications restate all eligibility requirements and disqualifying conditions, if those eligibility requirements and disqualifying conditions have not been materially modified. Furthermore, the time limit for distribution of a summary of material modifications of a plan imposed by 29 U.S.C. § 1024(b)(1) indicates that the plan administrator was not required to supply any summarization of the modifications to the plan at any time prior to Mr. Gridley's death.

The District Court found that the new overview brochure (Plaintiff's Exhibit 19) was a document which "summarized the material modifications in employee benefits coming into effect on January 1, 1986" (App. p. 40a). Nevertheless, the District Court rejected the employer's contention that the new overview brochure was a summary of material modifications of the plan, and

accepted Mrs. Gridley's contention that it was a summary plan description containing a critical defect (the absence of the "actively at work" condition) rendering it in violation of 29 U.S.C. § 1022(b).

The Third Circuit rejected the District Court's conclusion, setting forth four reasons why the new overview brochure was not a summary plan description. The Third Circuit's analysis of this issue is set forth in detail in Mrs. Gridley's Petition for Writ of Certiorari.

The merits of the Third Circuit's detailed analysis of the issue of whether the new overview brochure constituted a "summary plan description" is of less significance to the pending Petition for Writ of Certiorari than the fact that such a detailed, fact-specific analysis was necessary. The Third Circuit's analysis is tied to the particular facts of this case. No issues of general import are decided. The fact-specific analysis by the Third Circuit renders this case an inappropriate vehicle for pronouncements by this Court on issues of general import and national policy, relating to ERISA.

2. The United States Court of Appeals for the Third Circuit properly held that, under the facts of the instant case, ERISA provides no remedy for the disclosure violation.

The issue of whether the new overview brochure was, or was not, a summary plan description is actually of marginal significance. The real question presented by this case is whether, under the specific facts of this case, ERISA provides a remedy to the Plaintiff. We assume, for the sake of argument, that the employer was guilty of

reporting and disclosure violations, under ERISA Section 102(b), 29 U.S.C. § 1022(b). The question then arises as to what remedies ERISA provides for such violations.

This Court has had previous occasion to analyze the remedies provided by ERISA in *Massachusetts Mutual Life Insurance Company v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed. 2d 96 (1985). In that case, an ERISA plan beneficiary sought damages from a plan fiduciary based on the fiduciary's alleged failure to process claims in good faith and in a fair and diligent manner. In rejecting the Plaintiff's claim to a right to monetary relief, the Court stated:

> The six carefully-integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated and interdependent remedial scheme, which is in turn part of a "comprehensive and reticulated statute".
>
> 473 U.S. 146, 105 S.Ct. at 3093.

As noted by the Court of Appeals, ERISA expressly provides two causes of action to remedy reporting and disclosure violations: ERISA Sections 502(a)(4) and (c), 29 U.S.C. § 1132(a)(4) and (c) (App. p. 20a). Neither of these sections provide the remedy which Mrs. Gridley was granted by the District Court, nor are they at issue in the instant case.

Consistent with the dictates of *Massachusetts Mutual Life Insurance Company v. Russell*, supra, the Court of

Appeals concludes that, even assuming that the employer violated ERISA's Summary Plan Description requirements, no remedy is provided by ERISA in the instant case. The Court relies on its prior decision in *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1135 (3d Cir. 1990) to support its holding. The *Hozier* decision holds that an employer's reporting and disclosure violations were irrelevant to a determination of an employee's entitlement to benefits under terms of a severance plan, since ERISA fails to provide that remedy for such violations. The Court in *Hozier* notes some disagreement with the Ninth Circuit decision in *Blau v. DelMonte Corporation*, 748 F.2d 1348 (9th Cir. 1984) cert. denied, 474 U.S. 865, 106 S.Ct. 183, 88 L.Ed. 2d 152 (1985). As noted by the Third Circuit in *Hozier*, *Blau* held that "a Court must consider continuing (reporting and disclosure) violations in determining whether the decision to deny benefits was arbitrary and capricious." *Blau*, 748 F.2d at 1354. As further noted by the Third Circuit, the thrust of *Blau* seems directed toward mitigating the effect of the then established standard of review requiring a Court to defer to the plan administrator unless its decision were "arbitrary and capricious". The Court in *Hozier* suggests that the *Blau* holding has been rendered superfluous by this Court's rejection, in *Firestone Tire and Rubber company v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989), of the arbitrary and capricious standard of review, in favor of a de novo review of the plan administrator's decision.

Given *Blau's* focus on the standard of review, its significance is far from clear subsequent to *Bruch*. In any event, the concern of the Court in *Blau* is that "procedural violations may . . . work a substantive harm." *Blau*, 748

F.2d at 1354. That "substantive harm" is totally lacking in the instant case. The District Court in the instant case held that Mrs. Gridley could prove no detriment or damage, flowing from the employer's ERISA violations. Even if the employee Joseph Gridley had been fully informed of the actively at work condition in a summary plan description which complied in every respect with the requirements of ERISA, he would nevertheless have been unable to bring himself into compliance with the condition and render himself eligible for the increased life insurance benefit.

Mrs. Gridley, in her Petition, suggests that the Third Circuit decision allows for no remedy in the event of a violation of ERISA's requirements concerning summary plan descriptions. Her argument significantly overstates the effect of the Third Circuit's ruling. First of all, her argument ignores the fact that ERISA provides specific remedies for disclosure violations, at 29 U.S.C. § 1132(a)(4) and (c). Secondly, the Third Circuit's decision is limited, by the facts of this case, to instances where the disclosure violations have resulted in no harm or damage to the plan beneficiary. In rejecting a claim for a recovery in the absence of proof of detriment or prejudice flowing from the disclosure violation, the Third Circuit has decided this case consistently with the other circuits that have ruled on this issue. *See Govoni v. Bricklayers, Masons and Plasterers International Union*, 732 F.2d 250 (1st Cir. 1984); *Bachelder v. Communication Satellite Corp.*, 837 F.2d 519 (1st Cir. 1988); *McKnight v. Southern Life and Health Insurance Company*, 758 F.2d 1566 (11th Cir. 1985). In fact, the concern of the Court in *Blau v. DelMonte Corporation*, supra, with procedural violations working a substantive

harm, indicates that the Ninth Circuit would also require a demonstration of prejudice or detriment to support a recovery.

As noted by the Third Circuit Court of Appeals in the instant case, at App. p. 21a, the Sixth Circuit, in *Edwards v. State Farm Mutual Automobile Insurance Company,* 851 F.2d 134 (6th Cir. 1988) appears to take a different view, stating that "existing precedent does not dictate that a claimant who has been misled by summary descriptions must prove detrimental reliance." *Edwards,* supra, 851 F.2d at 137. This statement by the Sixth Circuit is *dicta,* since the Court finds that the beneficiary in that case "relied to his detriment upon the language of the summary." *Id.* Thus there does not appear to be a true conflict between the holding of the Third Circuit Court of Appeals and the holdings of any other circuits, in connection with the requirement that a Plaintiff demonstrate prejudice in order to recover for a disclosure violation under ERISA.

Given Mrs. Gridley's inability to demonstrate any detriment or prejudice flowing from the disclosure violation at issue in this case, the Third Circuit Court of Appeals decision in this case stands merely for the mundane legal proposition that, in the absence of explicit statutory authorization, a Plaintiff will be denied a remedy where she fails to prove any damage. Under these circumstances, the case before this court fails to provide an appropriate instance "to tamper with an enforcement scheme crafted with such evident care as the one in ERISA." *Massachusetts Mutual Life Insurance Company v. Russell,* supra, 473 U.S. at 147, 105 S.Ct. at 3093.

CONCLUSION

For the foregoing reasons, Respondent contends that the instant case presents no important question of federal law. The decision of the United States Court of Appeals for the Third Circuit does not conflict with the decisions of other circuits. Respondent requests that this action be concluded and that this Petition for Writ of Certiorari be denied.

Respectfully submitted,

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